LEGACY

Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals

KRISTA DE WIT

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Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals

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by

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With gratitude to Hanze University of Applied Sciences Groningen.

Dedicated to the healthcare professionals who work every day towards providing compassionate, person-centred care and to the courageous musicians working alongside them.

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PREFACE

On a cold December evening, just days before Christmas Eve in 2007, I played the violin to my dying father at the Helsinki University Hospital on the ward of oncology. I rushed to the hospital after a string quartet performance as a second year Bachelor student in the degree programme of Classical Music Education. I asked the oncological nurses if I could play the violin to my father, although it was already late in the evening. The nurses granted my request but asked if the other patients could also come and listen from a distance. Those who could not leave their rooms would have their doors open to hear the music, and those who would not want to hear it would keep their doors closed.

During the last days of his hospitalisation, my father received care in a private room. The door to the room was kept open much of the time, and it remained open during the time I played to him by his bedside: first, Adagio by Mozart followed by two pieces by Sibelius: Novelette and Romance. This was the first time I had ever played in a hospital but playing to my own father was a way of displaying love and saying goodbye. A day later he passed away.

While I was playing, nurses as well as patients had gathered outside my father's room: some sitting on the sofas in the centre of the hallway, some standing by and holding on to their IV-stands. Only later when I was packing up my violin, when I saw the people—many of whom were moved to tears—did I understand that the music I played in the intimate closeness of my father's private room had significance for the people outside. I got a sense of the meaning of live music in a hospital; not only for the patients, myself as a family member or a musician, but also collectively for the ward. This experience has understandably stayed with me, and it ultimately led me to become interested in researching live music practices in healthcare.

In 2010, my grandmother with advanced dementia moved into a nursing home in a rural town in central Finland. I began to collaborate with the caregivers of the nursing home by playing the violin for the residents in small, interactive living room concerts and by their bedside. The caregivers invited me to contribute to their collective events and activities; sometimes I was paired up with Santa Claus during Christmas time. These experiences sharpened my interest in researching the meaning of participatory music practices with vulnerable elderly people.

As the final professional integration project of my studies in the degree programme European Master of Music for New Audiences and Innovative Practice (NAIP), I designed, carried out and researched a new participatory music project with a group of native Finnish elderly people with dementia at a Finnish-language nursing home in Stockholm, Sweden (see Pyykönen, 2013). The project, "Many Memories, Many Stories" included eight interactive sessions, where the music-making happened on the residents' own terms and with collaborative support of an occupational therapist. By the end of the project, caregivers of the nursing home observed several positive outcomes of the project. They noticed an increase in the participants' social interactions, a growth of self-expression and confidence, ownership of the music-making, as well as an enhanced ability to recall the project and the musicians involved in it (ibid.).

After the music project finished in 2013, I tried to find ways to continue it. Yet, I struggled to engage the nursing home to carry on the practice with me. I came to suspect that the legacy of the music project had to do with the caregivers' resources for further collaborative commitment. Hence, questions like "what do the musicians leave behind after a music project ends?", and "what kind of learning and resources can be catalysed for the caregivers' everyday work through music-making?" seemed increasingly relevant to new research perspectives into participatory music practices in elderly care.

Meanwhile, in the research "While the Music Lasts" into the participatory music practice 'Music for Life' with elderly people with dementia, Smilde, Page and Alheit (2014) wrote: "The scene seems to be a 'legacy' of what could remain, following the intensive eight weeks of the Music for Life project: "it felt like the 'legacy of relationships'" (p. 224). Borrowing from their choice of words, the title of this research is "Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals". The title suggests appropriately that (a) the lens of this research focuses on the experiences of healthcare professionals who participate in live music practices on their workplace with the elderly people to whom they give care, and (b) the aim of the research is to find out what the music practices leave behind for the healthcare professionals' daily care work.

Although I have gained my previous experiences of music-making with vulnerable elderly people as a professional musician and workshop leader, the lens through which I am looking at this research is that of a music education researcher. When it comes to the phenomena of learning and social change through musical participation, the theoretical body of knowledge on social sciences and learning theories that I have built during my completed studies in the degree programme Master of Music Education (2013-2015) serves as a basis for embarking this research project.

Krista de Wit
Groningen, June 2020

1. INTRODUCTION

1.1. Global ageing and its growing occupational pressure on healthcare professionals

The world's population is facing a radical demographic change. In 2011, the World Health Organization stated that for the first time since the beginning of the recorded time, the number of people 65 years of age or older would soon outnumber the total of children under the age of five (WHO, 2011, p. 2). Worldwide, the number of people 60 years of age or older is expected to grow from what was approximately 901 million in 2015 to an anticipated 1,4 billion people in 2030 and nearly 2,1 billion in 2050 (United Nations, 2015, p. 9). The ageing of populations demands a comprehensive public-health response, and it is one of the greatest challenges facing contemporary healthcare providers and policymakers (Uhlenberg, 2009; WHO, 2015, p. 4; Office for National Statistics, 2018).

According to the European Parliament, vulnerability cumulates over the lifespan, and therefore, as the populations age, the number of older adults who can be considered vulnerable grows, as well (Lambert, 2013). For example, with ageing, the risk of chronic disease increases significantly (WHO, 2015, p. 26). Most prominently, the increased life-expectancy and rapid global ageing of the population combined, the prevalence of dementia[1] is growing worldwide (Uhlenberg, 2009; Hallam, Creech, Gaunt, Picans, Varvarigou & McQueen, 2011). This development contributes to an increase of elderly people in need of care both in hospitals and nursing homes (European Commission, n.d.).

Globally[2], around 47.5 million people have dementia, and in the 27 European Union member states the estimated number of people living with dementia ranges between 6.4 million according to the WHO (2015) and 7,3 million according to the European Commission (n.d.). As a response to the growing numbers of dementia in Europe, The European Parliament has called dementia out as one of the health priorities of the EU and urges member states to develop national dementia strategies (European Commission, ibid.).

So far, since 2002, there have been two international policy frameworks[3] for healthy ageing (WHO, 2015). In 2010, ALCOVE (Alzheimer Cooperative Valuation in Europe) Joint Action was launched and funded by the EU-member countries. One of the critical issues of the action was to investigate ways to improve care for people living with dementia, particularly those with behavioural symptoms (European Commission, n.d.). Additionally, EU-countries have developed separate national dementia plans. In the Netherlands, the European Dementia Prevention Initiative (EDPI) was launched in 2011 to create national dementia prevention strategies (Council of the European Union, 2015). Later initiatives have

1 Dementia is a term used for different types of progressive memory impairments that commonly cause difficulties in behaviour, communication and language skills, as well as processing, recalling and interpreting information (Smilde, Page & Alheit, 2014). Dementia interferes significantly with the ability to maintain activities of daily living (WHO, 2015, p. 59). The most common causes of dementia are Alzheimer's disease and vascular dementia (Kitwood, 1997).

2 Worldwide, an estimated 25-30 percent of people aged 85 or older have dementia (WHO, 2011, p. 3), and by 2030, it is estimated that more than 75 million people will be living with the condition (WHO, 2015, p. 59).

3 These policy instruments are *the Political declaration and Madrid international plan of action and ageing* as well as the World Health Organization's *Active ageing: A Policy Framework*.

since been put into action, such as a 'Longer at Home' programme, aiming for a delayed nursing home residency of people living with dementia (see Ministry of Health, Welfare and Sport, 2018a; Dons, 2019, p. 24).

Despite the growing attention on ageing and elderly care, a report by the World Health Organization (2015) points out that the healthcare agendas worldwide are insufficiently meeting the needs of the ageing populations. Although the urgency of ageing-related action has been recognised, the WHO reports that caregivers[4] may be unprepared to deal with the healthcare needs of older adults due to being trained to primarily identify and treat symptoms and conditions using a care approach that "does not prepare for the holistic perspective that has been shown to be most effective when caring for older people" (ibid., p. 94). A conventional *biomedical* care approach seems simply "inadequate to the needs of [the] rapidly increasing population living with dementia" (Power, 2010, p. 2).

Combined with the growing demands that the increasingly ageing populations add to elderly care, studies show that the healthcare sectors are already facing a critical shortage of healthcare professionals (Benner, 1984/2001; Bittman, Bruhn, Stevens, Westengard, & Umbach, 2003). In the Netherlands, for example, there will be an expected shortage of nurses up to 100 000-125 000 by the year 2022 (Ministry of Health, Welfare and Sport, 2017). What adds to the impact of the growing shortage of healthcare professionals is the ageing of the workforce, as well (Bittman et al., 2003). Consequently, while the general population ages, the gap in elderly care continues to widen. This development impacts the female workforce in particular because the majority of elderly healthcare professionals are women (Kubendran, DeVol & Chatterjee, 2016).

The growing demands on healthcare professionals include delivering consistently high-quality care to patients while "working irregular hours, [having] little autonomy, [coping with] increased accountability, [dealing with] growing bureaucracy and maintaining a good work-[private] life balance" (Lases, 2017, p. 14). These demands can put strains on healthcare professionals' occupational well-being (Youngson, 2012). Giving care to people with dementia, in particular, adds to the demands of healthcare professionals, as it requires more intensive care and longer working hours than regular care delivery (Kubendran et al., 2016). The stressors of the working life can cause poor health outcomes[5] for healthcare professionals and result to absenteeism or leaving the profession altogether (Lai, Li & Lee, 2011; Happell, Dwyer, Reid-Searl, Burke, Caperchione & Gaskin, 2013).

In the Netherlands, work absenteeism among healthcare professionals is high: 5.8% compared to 3.9% of the total workforce (Berenschot, 2017). Also, the number of nurses leaving the profession due to stress[6], heavy workload, dissatisfaction or exhaustion is

4 The WHO (2015) defines a caregiver "as a person who provides care and support to someone else; such support may include helping with self-care, household tasks, mobility, social participation and meaningful activities; offering information, advice and emotional support, as well as engaging in advocacy, providing support for decision-making and peer support and helping with advanced care planning; offering respite services; and engaging in activities to foster intrinsic capacity" (p. 226). A caregiver can be a healthcare professional, family member, friend, neighbour, a volunteer or a care worker (ibid.).

5 The poor health outcomes include physical illness such as inflammation and immunological problems, and psychological illness, such as depression and anxiety (Happel et al., 2012).

6 Work-related stress can cumulate into burnout. Burnout is a prolonged response to work stressors, and manifests in three dimensions: a feeling of reduced personal accomplishment, depersonalisation and emotional exhaustion (Ricard, 2013; Lases, 2017). Lases (2017) emphasises that burnout has a severe impact on the healthcare

increasing steeply (Ten Hoeve, 2018, p. 144). Ten Hoeve (2018) states:

> "Keeping well-trained and motivated nurses in the profession is not only a huge challenge but also a dire necessity. With an ageing patient population with high comorbidity and complex care demands, the need for good professionals will only increase. Therefore, it is inevitable that well-trained nurses be recruited and retained. This might be achieved by creating a work environment that leads to a high degree of commitment with their profession" (p. 144).

1.2. The need for cultivation of a person-centred care culture

Healthy workforce in any field of professional practice is a prerequisite for sustainable societal development and well-being (Kim, 2012). The challenges for the occupational well-being and thriving of healthcare professionals are known to be related to the economically-driven management models, overwhelming job demands and a task-centred care culture, which can create a negative work culture and hinder the healthcare professionals' capability to give wholesome care (Kitwood, 1997; Zeisel, 2010; Bunkers, 2010; Youngson, 2012). Without sufficient occupational support, some healthcare professionals can eventually start to feel "less engaged with [the patients'] care needs" (Ross, Tod and Clark, 2015, p. 1224).

Conventionally, healthcare has focused on the goals of disease management and has held a pathological view on ageing (WHO, 2015), which can be harmful to the healthcare professionals' occupational well-being as it hinders their abilities to focus on the humane aspects of the care (Youngson, 2012, pp. 2, 5). Humane care requires responsive and compassionate interactions (Van Heijst, 2005). It also requires a vision of a care culture that honours the care relationships and the patient's uniqueness, because, without a focus on humane care values, healthcare risks becoming inhumane (ibid., p. 209).

Person-centred[7] care offers an opposite approach to the "routinization, standardization and cost-cutting" of elderly care (Kitwood, 1997, p. 115). In the past years, person-centredness has become a cornerstone of measuring healthcare quality, which is reflected in the care policies and value statements of healthcare institutions (Ryan, Kinghorn, Entwistle & Francis, 2014). In the context of elderly care, person-centred care focuses on the elderly person's unique needs[8], experiences and preferences of the care planning, and considers

profession as it reflects negatively on work commitment and subsequently, the quality of the care. Fatigue and burnout can also lead to nursing errors (Chaudhury, Mahmood & Valente, 2009) and are associated with a reduced quality of patient care, loss of productivity, intention to leave the job, as well as social withdrawal (Youngson, 2012; Lases, 2017, p. 14).

7 The main elements that constitute person-centred care are providing comfort through tender and soothing care actions, supporting attachment and social bonding, building inclusion by reassuring the persons with dementia of their place in the shared social life, and supporting their occupation and agency by holding onto their abilities and a sense of identity (Kitwood, 1997, pp. 81-84). In literature, 'patient-centred' care is often used as a synonym for 'person-centred' care (see e.g. Ryan, Kinghorn, Entwistle & Francis, 2014). As this research focuses on two care contexts for vulnerable elderly people: hospital and nursing home care, it would be unfitting to use the term 'patient-centred care', since nursing home residents are not considered as patients even if they would be living with complex health conditions (see also Kitwood, 1997). Therefore, this research employs the term 'person-centred' care that is applicable in both of the care contexts of this research: hospitals and nursing homes.

8 According to a definition by the Health Innovation Network South London (HIN) (n.d.), person-centred care

ageing as a normal and valued part of the human lifespan (Kitwood, 1997; WHO, 2015, p. 103).

Elderly people and people with dementia, in particular, benefit[9] significantly from such care approaches that recognise their whole *personhood* in the everyday care (Kitwood, 1997, p. 8). Moreover, person-centred care has been found to contribute positively to the healthcare professionals' job satisfaction by reducing stress and emotional exhaustion and increasing a sense of accomplishment and meaningfulness of the work (Health Innovation Network South London, HIN, n.d.). The WHO (2015) explains that providing support and training in person-centred care for caregivers in nursing homes "can change their attitudes and actions towards people with dementia" (p. 140).

There are three urgent actions needed for positively transforming the care of vulnerable elderly people. These actions are first, shifting the clinical focus from disease to a person's intrinsic capacities; second, providing person-centred care (see above); and third, educating the caregiving workforce to meet the needs of the ageing populations better (WHO, 2015, p. 115). Finding ways to engage vulnerable elderly people and their caregivers in meaningful interactions is an essential part of promoting and cultivating person-centred care, which benefits both the healthcare professional and the care-recipient (Kitwood, 1997).

Meaningful engagement emphasises the need of relationship-oriented ways of working in healthcare. Youngson (2012) points out that "the relationship between the health professional and the patient is highly interdependent" (p. 78) and healthcare professionals who take the time to build "meaningful and personal relationships with their patients have less risk of burnout" (ibid., p. 80). Baart (in Adriaansen & Van de Pasch, 2008) explains that relationship-focused, person-centred care answers to what can be considered as the ideal of *good care*. To give good care, the contact with the person must come first, and only after, what the situation demands in terms of care actions (Baart, ibid.). Subsequently, healthcare professionals can identify as "caring human being[s] first" and as experts of the care practice second (Youngson, 2012, p. 92), which nurtures a compassionate culture of healthcare (ibid., p. 41).

As an outcome, healthcare professionals may begin to connect with the person's individual needs and engage with her/him with full attention (Baart in Adriaansen et al., 2008, p. 24). Such "magical moments" of connectivity (see Youngson, 2012, p. 17) can transform the care towards *good* person-centred care that is underpinned by communication and interaction, trust and mutual respect (Kitwood, 1997, p. 105). Finally, nurturing a person-centred care culture and creating so-called *care partnerships* can help to reinstate the balance of power and dependency between healthcare professionals and patients or residents (Power, 2010, p. 81; Foster, 2014, p. 9), and promote equality within the workforce, as well (Kitwood, 1997, p. 106). Kitwood (1997) adds: "If employees are supported and encouraged, they will take their own sense of well-being into their day-to-day work" (p. 103).

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respects the person as an expert on her/his own well-being, and also, acknowledge the physical, cultural and psychosocial environment of the care facility as part of the provided care that aims to answer to the person's individual needs.

9 Studies show that person-centred care not only improves the older person's positive experience of the care but also, it can improve their physiological health (e.g. blood pressure) and psychological well-being (e.g. depression) (Health Innovation Network South London, HIN, n.d.).

1.3. Harnessing cultural resources in elderly care contexts

Cultural approaches in healthcare highlight the potential of artistic participation for creating meaningful human experiences (Huhtinen-Hildén, 2013). During the past decades, cultural approaches and especially *participatory* (see section 3.2.5) arts initiatives have been recognised as a factor contributing to well-being in diverse healthcare contexts (Strandman-Suontausta, 2013; Fancourt & Finn, 2019). The arguments for the legitimacy of artistic and cultural activities as an integral part of healthcare are often based on article 27 of the Universal Declaration of Human Rights by the United Nations (1948): "Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits."

Research into the impact of participatory live music practices in healthcare has increased in the past decade, as the prevalence of live music in various care contexts has grown significantly[10] (Ruud, 2012). Live music practices in healthcare are considered as distinct from entertainment, music education and music therapy, which is articulated by the many organisations providing live music in healthcare today, e.g. Music in Hospitals (UK), Musique & Santé (France), Musicians on Call (US), Music for Life (UK), and the National Alliance of Musicians in Healthcare (UK), (see Preti & Welch, 2011, 2013; Ruud, 2012; Smilde, Page and Alheit, 2014; NAMIH, n.d.).

The growing prevalence of musicians working in the healthcare sector reflects on the numbers of conferences focusing on music, health and well-being, as well as educational programmes in institutions of higher music education, e.g. The Royal College of Music in Manchester (UK) (Preti & Welch, 2011; Oakland 2012) and Turku University of Applied Sciences (Finland) (Lilja-Viherlampi, 2013). It can be seen that professional musicians have established a role in healthcare primarily as artistic allies of the clinical care, enhancing the care environment and the patients' experiences of their hospitalisation, as well as promoting social well-being in the care community (Daykin, 2013). The collaborative relationship between healthcare professionals and arts practitioners, such as musicians, relies on establishing *dialogical*[11] communication (Rusi-Pyykönen, 2012).

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10 The phenomenon of professional musicians arriving into healthcare appears to be linked to the rapid development of the musicians' professional landscape, where the need to respond to the societal changes flexibly and connect to new contexts of work by developing 'portfolio careers' has never been more urgent (Smilde, 2007, 2010, 2014, 2018).

11 The term *dialogue* is used in many meanings in this PhD research. First, it is used in the context of establishing a mutual collaborative relationship between healthcare professionals and arts practitioners, specifically musicians. Second, it is used for describing communication which holds the values of reciprocity and openness in social interactions both in healthcare and in the field of participatory music. Third, musical dialogue describes the core values, approaches and processes of person-centred music-making (see section 3.2.5). Fourth, dialogue is a central term in the theoretical positioning of this research in social sciences. For example, the notions of dialogue as a necessity for the emergence of a community of practice (see Lave & Wenger, 1991 in section 3.2.2) and social interplay as a dialogue (see Goffman, 1959/1990 in section 3.2.4) exemplify the sociological uses of the term. Fifth, dialogue is used as a methodological term portraying the process of theory construction in grounded theory research, which requires the researcher to bring theory and empirical data into a dialogue (see chapter 4). Finally, the term dialogue is used in the analysis of the research (see chapter 5) when referring to the group discussion data of two or more interviewees having a conversation. Theories, such as "The Dialogical Self" by Hermans & Kemper (see Hermans, 2001) may have provided beneficial theoretical notions for defining *dialogue.* They were intentionally left out of this research because dialogue was not one of the emerging core categories of the grounded theory analysis

When it comes to supporting person-centred care through music, Vijinski, Hirst and Goopy (2018) explain that "as a social phenomenon and yet both introspective and personal, music offers an extraordinary opportunity to place the person at the centre of caring strategies" (p. 5). Similarly, Chadder (2019) argues that although few studies focus on healthcare professionals' perceptions of live music in their workplace, supporting holistic person-centred care seems to be a significant justification of live music practices in healthcare for their perspective (p. 5).

Although the concept of employing live music in healthcare is not new[12] (Edwards, 2007; Vijinski et al., 2018), the professional practices of musicians[13] and music therapists[14] have recently reached a shared territory of work. Consequently, the lines between the two disciplines have become increasingly blurred, all while operating with different agents, qualifications, training backgrounds and professional identities (Daykin, 2012; Ruud, 2012; Oakland, 2012; Wood & Ansdell, 2018). Therefore, it is important for this research to clearly define what is meant as participatory live music practices when investigating music-making as an artistic ally of healthcare professionals.

Most notably, participatory music practices in healthcare are artistically driven, which means that the musicians identify as professionals of music-making and operate in practices that are not designed to have any kind of therapeutic protocols or effects (Oakland, 2012; Preti & Welch, 2013). Still, the musicians' work in healthcare is heavily expertise-orientated (Oakland, 2012, p. 7), as they operate with a combination of professional skills, including the "necessary musical, performative skills, the methodological equipment, and theoretical familiarity, and not least, the personal, ethical, and political values to best carry out these health-musicking projects" (Ruud, 2012, p. 95).

A growing body of research suggests that healthcare professionals benefit from engaging in various forms of participatory music-making in their workplaces (Bittman, Bruhn, Stevens, Westengard & Umbach, 2003; Brooks, Bradt, Eyre, Hunt & Dileo, 2010). When it comes to artistic practices in healthcare supporting the well-being of healthcare professionals, a recent WHO report states participatory arts have been found to "improve mood and reduce stress while working, as well as improving levels of concentration, efficiency, enthusiasm and ordered working" (Fancourt & Finn, 2019, p. 28). Also, shared artistic engagement between healthcare professionals and the people to whom they give care "have been found to improve communication and carer intimacy behaviours towards

(see section 4.5.5.3). Most importantly, relevant perspectives on defining dialogue with oneself and other people in a situated social context of musical action have been covered in the theoretical body of this research (selected grand theories of learning, e.g. Mead, 1934) that are framing the analytical core categories. These theoretical and conceptual perspectives are explained fully in chapter 3.

12 Already in the mid-19th century, Nightingale's nursing philosophy recognised the value of sound in the clinical environment for stimulating recovery and considered music as distinct from other noise (Vijinski et al., 2018, pp. 2-3).

13 The musicians working in healthcare are referred to as, e.g. community musicians, care musicians, hospital musicians or health musicians, as a common professional profile is yet to be developed.

14 Around the same time that community musicians expanded their professional landscape to the healthcare context in the early 2000's, a new movement called community music therapy started to take root (Wood & Ansdell, 2018). Wood & Ansdell (2018) explain: "Increasingly, community musicians were training as music therapists, and music therapists were doing broader work in community settings, incorporating performances into their work, and talking about it in sociocultural "well-being" terms" (p. 456).

a care recipient, leading to closer emotional responses and physical behaviours." (ibid., p. 28).

Studies, thus, suggest that live music practices can promote meaningful social and artistic experiences in healthcare that can support healthcare professionals' well-being. Yet, what has remained to be thoroughly researched is how participatory live music practices might support the well-being of healthcare professionals in elderly care settings, in particular. Live music practices have been criticised for being offered in single projects (Huhtinen-Hildén, 2014, p. 10). Therefore, it is necessary to investigate *what kinds of changes* the projects leave behind when they end and *how* they contribute to creating supportive healthcare environments that nurture "those who live and work there" (see also Power, 2010, p. 189).

1.4. Aims and focus of the research

This research examines the relationship of artistic participatory live music practices that emphasise music as a way to enhance communication and well-being *in the moment* and healthcare professionals' experiences and learning thereof. The focus of this research is the legacy of participatory music practices as a resource for the occupational well-being of healthcare professionals, and their learning about communication with their patients or residents in two elderly care contexts: caregivers in nursing homes and nurses in a hospital. The research focuses on healthcare professionals giving care to elderly people with dementia and those working with elderly people undergoing surgery[15].

This research investigates individual healthcare professionals' personal experiences and learning, as well as the collective meaning-making of colleagues within work communities. The intention is to find out what musical communication can contribute to the healthcare professionals' occupational well-being and their contact with their patients or residents. Therefore, the selection of suitable music practices to research had two main criteria: first, this research examines such participatory music practices with elderly people that recognise healthcare professionals' agency and learning in the musical processes and second, it focuses on music practices in the Netherlands. Limiting the research to music practices in the Netherlands was not only relevant because of the significant pressure facing the Dutch healthcare sector due to a combination of ageing and shortage of workforce, but also, practically suited because the Netherlands is my country of residence.

When it came to the choice of music practices with a focus on the healthcare professionals' agency, two participatory music practices in the Netherlands, *Meaningful Music in Healthcare (MiMiC)* and *Music and Dementia* were deemed suitable[16] for this research.

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15 The number of elderly patients in hospitals is increasing, and surgical elderly patients are especially vulnerable for complications after surgery (Smilde, Heineman, de Wit, Dons and Alheit, 2019). Studies suggest that elderly patients have an increased risk of experiencing post-operative delirium; an acutely altered mental status that can cause hallucinations, inattention and altered levels of consciousness that significantly complicate their recovery (Robinson & Eiseman, 2008; see also Inouye, Westendorp & Saczynski, 2013; Rivosecchi, Smithburger, Campbell & Kane-Gill, 2015). Complementary non-pharmacological approaches combined with the medical treatment have been found beneficial for preventing delirium in older patients (see Abraha, Trotta, Rimland, et al., 2015).

16 During the selection process of the music practices that began in Spring 2015, I first chose Music and Dementia as an empirical study, because it was already established in the Netherland. Besides, I had a considerable

I have been involved[17] in both music practices. In these two music practices, healthcare professionals' engagement in the music sessions is considered as essential for creating social change within the care contexts (Smilde et al., 2014; Smilde, Heineman, de Wit, Dons & Alheit, 2019). In both practices, the musicians and caregivers work collaboratively to engage the patients and residents in the music-making. Simultaneously, the possibilities for the healthcare professionals' experiential learning are recognised and supported (see section 2.3). Additionally, both practices have a direct link to the musicians' professional training in higher music education (see section 2.3), which means that the findings of this research can inform the contextual knowledge development of (novice) musicians working in the two music practices in the Netherlands.

The data collection on the two empirical studies was carried out in the Dutch healthcare context between 2016-2019. The data collection in the short-term care context of elderly surgical patients focused on the new professional practice for musicians, Meaningful Music in Health Care (MiMiC) at the University Medical Center Groningen (UMCG), where it took place on three surgical wards between 2016-2017. The wards of the UMCG were Traumatology, Oncological Surgery and Vascular and Hepatobiliary Surgery. On these wards, the majority of patients were elderly people over 60 years of age, although these wards were not geriatric units. The data collection largely overlapped with the developmental phase of the new MiMiC practice in 2015-2017 (see section 2.3.1).

Further, this research aims to address what participatory music-making can offer to the learning and well-being of caregivers giving care to elderly people with dementia. In the long-term care context of nursing homes, the research focuses on the caregivers' experiences and meaning-making[18] of the participatory Music and Dementia practice. The data was collected between 2016-2019 by following three Music and Dementia projects in different Dutch nursing homes. The practice was launched in the Netherlands based on a research study into the *Music for Life* programme in the UK (see Smilde, Page and Alheit, 2014 in section 2.1.1).

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pre-understanding of participatory music practices with people with dementia both as a musician and a workshop leader through my own work and previous studies (see Pyykönen, 2013). Thus, the aims of participatory music-making and the need for collaboration between musicians and healthcare professionals within the musical processes were familiar to me.

Later in Autumn 2015, the development of a new MiMiC practice in the Dutch short-term hospital care context offered an opportunity to extend my PhD research. So, the scope of the research widened from exclusively looking into participatory music-making in Dutch nursing homes to investigating practices in two very different Dutch elderly care contexts: short-term and long-term care. I considered this as an opportunity for gaining a wider horizonal understanding, as the research approach enabled me to make comparisons of the data between the two contexts.

17 A supporting element of the selection was that I was able gain a closer understanding of the music practices as a musician. Fortunately, I was able to work as a musician in both practices (MiMiC and Music and Dementia) between 2015 -2020. Through these experiences, I gained a sense of closeness with the practices as I have collaborated with the healthcare professionals musically in the music sessions. I have reflected upon these insights into the musical processes and interactions in my research.

18 According to Ascenco, Williamon and Perkins (2016), *meaning* has been defined as the ontological significance of life for an individual and "is closely linked to purpose and stands as a highly subjective element" (p. 68). It can also be defined as "the feeling of belonging and serving something larger than one's self" (ibid., p. 68). Meaning has to do with worthwhileness and a sense of self-transcendence or direction (ibid.).

1.5. Research questions and intended contributions

The goal of this research is to explore participatory music-making as a complementary means of supporting healthcare professionals' occupational learning and well-being. In wider terms, this means exploring how participatory music practices can contribute to building *environments informed by the arts* (after Moss, Nolan & O'Neill, 2007) for the benefit of the healthcare professionals and their care delivery to the ageing patients or residents. The interest of this research is, thus, to find an answer to the following research questions:

1) *What kind of knowing is transferred from interactive music sessions into daily healthcare practices in elderly care and hospital settings?*

2) *What resources and social changes can music sessions generate for the nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?*

The findings of this research are intended as a contribution to the discourse on participatory music practices in healthcare and their potential for supporting the occupational job resources of healthcare professionals working in the increasingly demanding elderly care settings. Furthermore, this research aims to bring about new awareness of the impact of participatory live music practices beyond the usual research focus on the patients or residents' well-being. Hence, instead of focusing on the plentifully researched changes that participatory music-making can create in the lives of vulnerable elderly people, this research aims to steer the attention to the less-explored experiences of the people giving care to them. The findings of this research can be applied in the further professionalisation of musicians working in healthcare, as well as in the occupational training of healthcare professionals.

1.6. Outline of the dissertation

This monography contains six chapters. The introduction (chapter one) lays out the global phenomena framing the research topic: ageing of populations, the demand for person-centred care, the strains and occupational fatigue of healthcare professionals, and the emergence of new participatory live music practices in healthcare, as well as the focus and positioning of this very research.

Chapter two focuses on the findings of a forestudy into two established practices (Musique et Santé and Music for Life), and the two music practices (Meaningful Music in Healthcare (MiMiC) and Music and Dementia) in the empirical studies of this research. The attributes of the Dutch healthcare framework where these practices exist are also explained.

Chapter three presents the theoretical and conceptual framework underpinning this research. Key concepts of experience, participation and learning, as well as core definitions of health and well-being, participatory and person-centred music-making, compassion, and mindful presence are defined. Chapter four describes the methodology, the empirical research methods and the grounded theory approach of the research, and weighs in

critically on the limitations of the study.

Chapter five unwraps the analysis and findings of the research. The interpretative analysis is written in a form of a thick description and brings about relevant comparisons between the two empirical studies of the research as they emerge.

In chapter six, the conclusions and discussion focus on the relevance of the findings for the field of practice. The dissertation finishes with recommendations for practitioners on both sides of the collaborative practice: musicians and healthcare professionals. Finally, the dissertation suggests new perspectives for further research.

1.7. Notes on key terminology and references to raw data

1.7.1. Key terminology

Key terms will be reviewed in order to present both the data and their relevant contexts accurately. The participants of this research in both music practices, MiMiC and Music and Dementia, will be collectively referred to as 'healthcare professionals.' However, to avoid unnecessary complexity and contextual indistinctness of the analysis, the participants of the MiMiC practice in the short-term care context of the hospital will be referred to as 'nurses', and the participants of the Music and Dementia practice in the long-term nursing home care context will be referred to as 'caregivers' when addressed separately. See chapter 4 on Methodology for a detailed description of the research sampling.

1.7.2. References to raw data

This PhD research was connected to the development of the MiMiC practice (2015-2017). Hence, the research data that I collected and processed was used not only for my PhD research but also as a contribution to answering the main question of the MiMiC research: "*What does music actually 'move' in the hospital settings?*" (Smilde, Heineman, de Wit, Dons and Alheit, 2019, p. 14). With this separate research lens of the MiMiC research, I used my PhD-data for interpreting the social changes catalysed by the MiMiC practice for nurses in the form of a 'learning pathway' (see section 4.3 in Smilde et al., 2019, pp. 94-116). I constructed the learning pathway based on the coding consensus of the MiMiC researchers (see ibid., pp. 27-30). Consequently, some of my raw data and empirical descriptions of musical situations in the MiMiC practice have already been published in the book "If Music be the Food of Love, Play On" (see Smilde et al., 2019, pp. 39-42; 47-50; and 94-116).

Subsequently, in regard to my analysis of this PhD-dissertation on the MiMiC practice, I am referring to my already published data in Smilde et al. (2019) in certain sections of the analysis (see chapter 5). However, I am interpreting the data for my PhD research through a different research lens, research questions (see section 1.5) and coding processes than I did in the completed MiMiC research. Therefore, I have also re-shaded the participants' names for this dissertation to best support my original theory formation and reconstruction of the data. Also, I left out some parts of my observation descriptions featured in the published MiMiC research (e.g. the musicians' reflective commentary on the musical situations) when they did not serve the focus and analytical conveyance of this PhD dissertation. For the

sake of academic integrity and maximal transparency, in the thick description of this PhD dissertation, I will add a footnote with a full reference to each fragment of data that has previously been published as a contribution to the MiMiC research (Smilde et al., 2019).

2. POINT OF DEPARTURE: FORESTUDY AND CONTEXTUAL SENSITISATION

2.1. Forestudy on pioneering practices in healthcare: Music for Life and Musique et Santé

In order to gain contextual familiarity with and first sensitising concepts (see section 4.1.3) for this research, I conducted a forestudy on two established European artistically driven participatory music practices that use person-centred approaches to music-making in elderly care settings. These practices are Music for Life[19] in the UK and Musique et Santé[20] in France. Both are well-known long-running practices that pay special attention to the learning, well-being and professional development of healthcare professionals in the context of the music practices. Music for Life has been influential for the development of subsequent practices, such as Music and Dementia in the Netherlands, which was developed through research into Music for Life by the research group Lifelong Learning in Music (see Smilde et al., 2014). Musique et Santé has informed other music organisations and programmes which offer live music in healthcare contexts, such as OPUS Music in the UK and Care Music in Turku, Finland (see NAMIH, n.d.; Lilja-Viherlampi, 2013). I carried out a forestudy on Music for Life and Musique et Santé in 2015-2016 with a focus on the learning, well-being and participation of healthcare professionals.

In the framework of Music for Life in the long-term care settings, I conducted semi-structured expert interviews and two group discussions with the following experts:

- Linda Rose, founder of Music for Life
- Kate Whitaker, former coordinator of the Music for Life programme at Wigmore Hall
- Padraic Garrett and Fionnuala Baiden, Staff Training and Development coordinators of Jewish Care
- Lucy Payne, Music for Life musician
- Graham Freeman, manager of Leonard Sainer Center community centre for people with dementia
- Debra Fox, Staff Training and Development coordinator of the organisation Jewish Care

19 Music for Life was developed in 1993 by music educator Linda Rose. It has been developed in association with the organisation Jewish Care since 2009, and it is managed by Wigmore Hall in London (Smilde et al., 2014). Music for Life offers a series of interactive creative music workshops in nursing homes and day centres for people with dementia in the United Kingdom.

20 Musique & Santé, founded in 1998, is a non-profit organisation in France. It has been commissioned by the French Ministries for Culture and Health to carry out and develop cultural projects in hospitals in France and in Europe for diverse patient groups from infancy to the end of life. As a coordinator of a European network "Music in Healthcare Settings", Musique & Santé conducts projects with the support of the European Commission (Musique & Santé,, n.d.) Musique et Santé (ibid.) describes their focus as "advocating and working for the development of live music in hospitals and institutions for disabled persons." Their activities in geriatric hospitals care take place in the following units in Paris: Émile-Roux, Paul-Brousse, Sainte-Périne, and Institut Gustave Roussy (ibid.). The interviews of this forestudy took place at the Rossini-hospital, which belongs to the Sainte-Périne-unit.

The expert interviews with Lucy Payne, Kate Whitaker and Debra Fox, as well as the group discussions with Graham Freeman and Linda Rose and later with Padraic Garrett, Fionnuala Baiden and Linda Rose took place in London on November 4th, 2015. Additionally, I observed one Music for Life session at the Leonard Sainer Centre in London the same day.

In the framework of Musique et Santé carrying out live music sessions with vulnerable geriatric patients, I conducted semi-structured expert interviews with the following experts:

- Chantal Lavallée, musician and trainer of the organisation Musique et Santé in Paris
- Mohamed Bouazouzi, social care coordinator of Hôpital Rossini-geriatric hospital
- Laurence Vilmot, social worker at Hôpital Rossini-geriatric hospital

Additionally, while in the location, an opportunity presented itself to hold an unplanned informal group discussion with three geriatric nurses working at Hôpital Rossini. The expert interviews with Chantal Lavallée, Mohamed Bouazouzi and Laurence Vilmot, as well as the informal group discussion with the three nurses, took place on May 2nd and 3rd, 2016 at the geriatric Rossini-hospital in Paris.

2.1.1. Music for Life: person-centred improvisation with elderly people with dementia

AIMS AND APPROACHES

In the Music for Life practice, a trio of professional musicians work together with eight nursing home residents or day centre clients and three to five members of the caregiving staff[21] (Smilde et al., 2014, pp. 3, 253; Wigmore Hall, n.d.) in hour-long music sessions for eight weeks. The musicians create person-centred improvisations, which they use to engage the participants in the music-making. Smilde et al. (2014) explain: "Music for Life projects aim both to enhance the quality of life of its participants and to demonstrate to staff the emotional, social and physical potential of people in their care" (p. 252). A shared debrief among the musicians and the caregivers follows each of the project's eight weekly sessions. In addition, the caregivers take part in separate staff development sessions with a 'Training and Development Facilitator' from the Jewish Care Disability and Dementia team or the Music for Life team to discuss their experiences and observations of the shared musical processes.

To support person-centred care in nursing homes, Music for Life aims to *develop the caregivers* (Garrett, 2009). The aim is to facilitate the staff to look at the residents laterally from the perspective of *person-centredness*[22] instead of *task-centredness*, which can open opportunities for improving the communication between the caregivers and residents.

21 Ideally, the same members of care staff will be involved in the project consistently throughout the full eight weeks of sessions. This may require some adjustments among colleagues and team leaders. The projects are open for staff members with diverse professional functions, e.g. care assistants, kitchen workers, social care coordinators, and caregivers (Smilde et al, 2014, p. 254).

22 Music for Life has taken an approach of person-centred care as its foundation, believing that music-making together provides an environment where 'the person comes first', and people can be seen as individuals with their own personal narratives, preferences and emotions. It also means recognising the capacity of those living with dementia to contribute to the collective social experience.

According to Debra Fox[23], this means "*delivering the message of person-centredness, enabling possibilities of learning through the sessions, and then, taking that to the everyday care.*" On a broader level, the goal is to catalyse lasting change in the culture of caregiving. Padraic Garrett[24] explains:

> *We recognize that there is a variety of cultures within our homes and centres. Staff teams can be at various places within those cultures, but we are looking at a spectrum of staff teams who are very person-centred; who are really working from a relationship-focused place. That is where we are aiming to be at.*

Padraic Garrett stresses the need to start from a place of acknowledgement of the caregivers' expertise: "*By this stage, they are the very experts in dementia. What I mean by experts, I mean people who have experience with engaging with people with dementia.*" Respect and support for their know-how is crucial for the success of the music project. Padraic Garrett explains: "*I think the primary outcomes would be that [the caregivers] feel valued, respected, affirmed, motivated. […] That they would experience for themselves what the person-centred relationship-focused approach is.*" Linda Rose[25] adds: "*They have to feel validated; they have to feel that it is for them as well.*"

Therefore, those caregivers who have limited training for working with people with dementia are especially supported by the 'Training and Development Facilitators'. A significant part of the learning happens through observing the musicians' ways of communicating in the music session. Padraic Garrett describes: "*All the non-verbal clues [the musicians] are constantly picking from one another. They come with highly tuned skills that they are applying to communication within dementia.*" Padraic Garrett explains that through the collaborative processes of the sessions, knowledge is shared from one discipline to the other: "*I think staff, by watching and being with those very skilled musicians who are skilled in dementia, as well, learn. […] Similarly, [the musicians] do acknowledge the skills of the staff.*"

The catalysed learning processes and social changes are connected to experiencing the music practice first-hand as a group. Lucy Payne[26] says:

> *Then, you build relationships, and those staff members and those residents form a different relationship. That might affect how the staff reacts to other people, and you know, it can give them tools to cope with the difficult behaviour that you get. […] And that happens through shared experiences, I think. Music is brilliant for that because it strips away a lot of their fronts. Strips away; you can get to a core of what people are.*

The learning is, thus, above all social. Kate Whitaker[27] adds:

> *[The staff] are not just talking about the residents, they are talking about everyone, the closeness and the aim of individual connection […] And often, they learn totally new things*

23 Interviewed in London on November 4th, 2015.
24 Group discussion in London on November 4th, 2015.
25 Group discussion in London on November 4th, 2015.
26 Interviewed in London on November 4th, 2015.
27 Interviewed in London on November 4th, 2015.

> *about themselves and the people they work with, and about their colleagues, so I think that is maybe something they view as valuable.*

Padraic Garrett sums:"*They are in a group together. They are doing it together as equals.*"

The catalysed changes in the culture of care may lead to caregivers implementing their new insights that have emerged from the music sessions into the care or even singing to their residents during care routines. Some of the fundamental challenges for creating a lasting impact on the care are, however, the outsourcing of temporary staff and the growing professional turnover of caregivers that create a constant flux in the workforce. Another challenge is spreading the new insights from the music sessions into the whole community of colleagues in the nursing home. Linda Rose explains:

> *There is a need for the project to see itself as part of the wider community in the home […] and I think that is an ongoing challenge that other members of staff can feel that they are left out of something.*

The legacy of a Music or Life project rests on the experiences and reflection of the caregivers. They need encouragement to reflect upon their *own* experiences. Padraic Garrett states:

> *One of the things that I would always feel is that there is a temptation to move from a Music for Life session into a discussion about residents very quickly. That does a disservice to the staff.*

Talking about the residents' behaviours is often more familiar to the caregivers than talking about their own experiences. Padraic Garrett continues: "*Of course, they are really eager to do that bit; to talk about the residents, but the deeper scale is how do you get the staff to focus on themselves a little bit?*" Kate Whitaker emphasises that at its best, the meaning-making can have real personal significance to the staff:

> *You don't only improve their care, you improve their sense of confidence, their sense of what they're doing, and that is totally vital. So, to say that probably was the core of the work, it's both helping the staff to feel their worth and to really help them embed that person-centred learning. And maybe open up more creative attitudes to their work as well, so thinking both artistically and just thinking flexibly.*

Graham Freeman[28] explains that the caregivers are recruited to the project based on their interest, motivation, personality and character, or a need for encouragement to communicate more with the residents. The managers of the care units need to be very well-informed about the goals of the practice because support is crucial for the caregivers' engagement and commitment to the music project. Sometimes, the caregivers feel apprehensive to participate due to their workload on the ward, which highlights the need for management support. Kate Whitaker explains: "*It is not like they do not want to participate; it is just that they feel genuinely like: 'if I do not do this, it is not going to happen', and they feel that*

28 Group discussion in London on November 4th, 2015.

would be irresponsible of them." Padraic Garrett reflects: "*[…] we are in a culture of 'doing' all the time. […] People seem to affirm one another for being hard-working and busy.*" Padraic Garrett continues:

> *We need to make that time for the staff and reinforce the importance of being with people, sharing time with people. […] Essentially, it is validating that to sit and be with a group of people is work. It is a wonderful part of our work, but we do not value it.*"

Linda Rose adds: "*To learn to sit back. … It's a learning process just to learn to be an observer. Building those observation skills and learning to value them is part of what that role is about.*"

Padraic Garrett sums: "*It is such a powerful thing for [the caregivers] to have that time. It is something we have to emphasise. One of the values of Music for Life is to emphasise the value of that.*"

2.1.2. Musique et Santé: Individualised music for vulnerable geriatric patients

AIMS AND APPROACHES

The Musique & Santé organisation aims to contribute to the quality of healthcare through the following objectives (see Bouteloup, 2010, p. 2):

1) Humanisation[29] of hospital care by creating new perspectives for the participants through music.
2) Creativity and shared experiences by facilitating an artistic discovery through music to open a "*window […] to the outside world*" (ibid., p. 2).
3) Creating a dialogue that can serve as a common ground for "*a climate of trust between hospitalised people, families, and healthcare staff*" (ibid., p. 2).
4) Competences and professionalism of the Musique et Santé musicians, which are ensured by specific training and contextually appropriate approaches.
5) A sustainable partnership that builds upon collaboration *"so that music can become an integral part of the units*" (ibid., p. 2). The aims of sustainability include training sessions that are offered to healthcare staff.

Musique et Santé stresses that their musicians are artists who have been trained to develop competencies that enable them to work towards the humanisation of healthcare through collaboration and dialogue with the healthcare professionals (Bouteloup, 2006; 2010). Through the musical interactions, the medical nurses can *re-discover intersubjectivity* with their patients; learn to value the interactions with the patients more and eventually build

29 The activities of Musique et Santé stand under the French National Policy for Culture and Health that dates to 1999 when the "Culture in Hospital" agreement was signed by the Ministry of Culture and Communication and the Health and Social Action Secretary of State (Gay, 2012, p. 17). The agreement was founded on the goals of making the healthcare settings more humane, developing the care of patients and their families, improving the work environment of healthcare professionals and facilitating professional artists to interact with audiences in unconventional ways (ibid.). A new national agreement "Culture and Health" was signed in 2010, in which the personal, professional and social factors of cultural activities were acknowledged as a contribution to the healthcare policy (ibid., p. 18).

deeper dialogical care relationships with them (Cohen-Salmon, n.d., p. 3). Such change is catalysed by witnessing the interactions between the musicians and the patients and their musical communication (ibid.). Cohen-Salmon (n.d.) continues that the shift towards person-centred care can have a significant effect on nurses' burnout prevention because staff burnout can, among other factors, be related to a lack of personal relationships with patients (p. 3).

In the geriatric hospital Rossini, Musique & Santé has been integrated in the social care activity plan since 2007 in monthly one-to-one music sessions in the patient rooms. The social care programme emphasises building personal relationships with the patients and creating liveliness in the clinical settings of the geriatric care, Mohamed Bouazouzi[30] explains. According to Laurence Vilmot[31], geriatric patients are very vulnerable and have usually several conditions. Some pass away shortly after being hospitalised, but many require long-term hospital care. Therefore, social care has a specific focus on stimulating long-term patients. Musician Chantal Lavallée[32] specifies that the priority of the music sessions is to spend time with those patients who are no longer able to take part in the other musical activities outside their rooms.

Mohamed Bouazouzi describes that the Musique et Santé-sessions fit well in the person-centred care aims of the hospital:

> *All the patients are first social persons, so we try to create activities that involve their personhood. […] The meaning is to meet the people, to make the hospital not just a bed but a place of life.*

Chantal Lavallée starts each music session with a brief with the social workers to gain up-to-date information about the patients. Then she meets with the nurses of the ward to obtain additional input about the patients before beginning the session. During the session, she works for three hours on the ward, visiting patients individually in their rooms. A social worker may observe the session and write notes that are used for an evaluation. After the session, Chantal Lavallée may hear feedback from the nurses:

> *Sometimes, I do not see the nurses afterwards, but they will tell the social workers: 'Mrs. is asking for [Lavallée] again', or 'Mr. has slept so well that night, we did not have to give him his medicine or sleeping aid', or 'this woman ate so well that night.'*

In the end, each evaluated project is reported to the medical and administrative heads of the hospital.

At Rossini, staff training (French: *formation)* is offered to the healthcare professionals by the musicians of Musique & Santé. The goal of the training is to invite the healthcare staff as a team to engage in reflection on their ways of working and handling difficult situations with patients. *Presence*[33] is a fundamental concept of the training. The training is aimed to be as inclusive for the staff as possible so that the professionals of different specialisms

30 Interviewed in Paris on May 3rd, 2016.
31 Interviewed in Paris on May 2nd, 2016.
32 Interviewed in Paris on May 2nd, 2016.
33 See section 3.3.3.3 for definitions of presence as a core value of healthcare practice.

can come together to discover how live music and singing[34] could help their work with the patients. Mohamed Bouazouzi concludes:

> *The real benefit of the training is to mix different types of professionals, as they talk together without the apprehension or judgement of their profession: 'I am just a care assistant, she is a nurse.'*

The staff training aims to create small changes in the staff members' attitudes towards a relationship-based way of working; to build acceptance and acknowledgement of artistic approaches as part of the geriatric care, and to create calmness and relaxation for the healthcare professionals. Mohamed Bouazouzi explains:

> *You can become more 'zen', calmer and de-stressed. […] And we try to move the nurses to this way of working; to have more patience with the patients, to engage in the relationship.*

As an outcome, the nurses can become more self-assured in their communication with the patients. A male geriatric nurse[35] reflects on the impact of live music on his work: "*I would say it changes the atmosphere. It is something different, it is more like the everyday life. […] It makes the atmosphere more joyful*."

Time pressure is a significant limiting factor for the nurses' engagement in the sessions and implementation of music in their care delivery. The geriatric nurse continues: "*We do not have a lot of time to do it ourselves. So, that is why we need the help of the musicians, actually.*" The social changes in the medical care culture remain subsequently subtle. At the beginning, the nurses were sceptical about the music sessions, but this has changed. Chantal Lavallée confirms: "*It means so much for them [now].*" These changes among the medical staff echo the actions of the social workers[36]. Yet, to facilitate staff learning through the Musique & Santé projects, Mohamed Bouazouzi stresses the importance of managemental support for the staff participation in the music sessions, as well as regularity of the music sessions.

2.1.3. Summary of the forestudy: From interpretive findings to first understandings

Through reflection on the findings of the forestudy, it seems that the work of Music for Life and Musique et Santé lies on person-centred approaches to musical communication. These approaches are used for sparking social change in the culture of care delivery. The musical processes happen in dialogue and collaboration with the healthcare professionals. The social changes are brought upon by the healthcare professionals' experiential learning in

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34 Practically speaking, the staff training aims to promote the use of singing while performing daily care routines to dissolve conflict with agitated patients, to improve the patients´ experiences of e.g. toileting or washing, and to find a way to connect and communicate with the patient on a personal level. In between the training sessions, the healthcare professionals are encouraged to try out musical approaches in their work, and then in the following session, share their experienced of doing it.

35 Group discussion in Paris on May 2nd, 2016.

36 Through the music practice, the social workers have developed new musical approaches in their work, such as weekly singing (Laurence Vilmot, May 2nd, 2016). The singing can change the atmosphere in the patient's room, which may help the patient to relax. Relaxation, in return, supports the performance of care routines. The music sessions can, subsequently, help the staff members to find confidence in their own musical capabilities.

the music sessions, as well as the facilitated reflective practice on their ways of working. The music projects seem to promote presence, calmness and taking time in order to build a relationship-focused care culture amid the hectic working life. To accomplish that, support from the work community and managers appears crucial.

The forestudy suggests that healthcare professionals in both contexts can gain new recourses for their work, such as the ability to engage with and relate to the patients or resident on a more *human* level, through new insights emerging from the music sessions. These first impressions are in line with Garrett (2009), Bouteloup (2010) and Smilde et al. (2014). To create a ground for a lasting impact on the healthcare professionals' working culture, it seems imperative to include healthcare professionals with various job titles in the music-making and encourage sharing insights into the musical processes within the broader care community. These interpretative findings of the forestudy inform the first understandings (see *sensitising concepts* in section 4.1.3) of the main study of my research.

2.2. Contextual positioning of the study: Healthcare in the Netherlands

The healthcare system in the Netherlands is considered as one of the best by world-wide comparison (Lases, 2017, p. 24). The following principles are underpinning it: equal access to care for all, solidarity through medical insurance, and high-quality care services (Ministry of Public Health, Welfare and Sport, 2018b, p. 3). These principles are part of the Dutch *value-based* healthcare framework that adopts a holistic view on the patient and her/his preferences of treatment and care (Dons, 2019, p. 26).

Four healthcare acts govern the Dutch healthcare system: the Health Insurance Act (encompassing short-term care including hospital care), the Long-Term Care Act (encompassing permanent support or 24-hour home care for vulnerable people, including nursing home care), the Social Support Act (encompassing different forms of support for home assistance) and the Youth Act (supporting the everyday living of families with, e.g. children with special needs) (The Dutch Ministry of Health, Welfare and Sport, 2018b). The Dutch Ministry of Health, Welfare and Sport (ibid.) states that these healthcare policies are considered as "opportunities to improve the quality of the care provided, promote an integrated approach and keep healthcare available in times of an ageing population and in which many people suffer from chronic illnesses" (p. 4). This research focuses on the short-term (hospital) and the long-term (nursing home) care contexts and therefore positions its investigative lens on the areas of the Dutch healthcare system that are governed by the Long-Term Care Act and the Health Insurance Act[37].

When it comes to the professional training of the Dutch healthcare workforce, the Dutch education system produces highly knowledgeable professionals holding Bachelor, Master's and Doctoral level degrees in nursing (Ten Hoeve, 2018, p. 13). In addition, the caregiving workforce in the Netherlands includes caregivers with lower level vocational training (MBO-V) (ibid.), especially in the long-term care context. Since 2002, the Netherlands has operated according to the Bologna Agreement of 1999 that reformed

37 The Long-Term Care Act as was established in its present form in 2015. It is controlled by long-term care administrators of the central government (The Dutch Ministry of Health, Welfare and Sport, 2018b, p. 4). The Health Insurance Act, however, is systematised by private health insurance companies (ibid., p. 4).

nursing education in Western European countries into a unified European platform and changed the curricula of nursing in higher education[38] (ibid., p. 12).

2.2.1. Short-term hospital care in the Northern Netherlands

This research examines two participatory music practices in the Netherlands, MiMiC and Music and Dementia. All four of the observed MiMiC projects took place in the northern province of the country, Groningen, at the University Medical Center Groningen (UMCG)[39]. According to the UMCG (2010), in 2008, "nearly 11.5 per cent of the 2.4 million people aged 65 or older in the Netherlands were living in Groningen, Friesland and Drenthe, accounting for 14 percent of the inhabitants of these provinces" (p. 3). Therefore, the Northern Netherlands as a region is especially appropriate for research into participatory music practices with elderly people.

As explained, the data on the MiMiC practice was collected at the University Medical Center Groningen, which is one of the largest hospitals and medical employers in the Netherlands (UMCG, n.d.). The hospital's clinical care, medical education and scientific research have a particular focus on healthy ageing[40] (ibid.). The reason for the focus on healthy ageing is that frail elderly hospital patients tend to have a combination of complaints, both physical and psychological. So, the UMCG has developed a person-centred care approach that focuses primarily on the well-being of elderly patients (UMCG, 2010, p. 5).

The central interests of knowledge regarding elderly patient care are: first, what kind of care benefits frail older patients, and second, how person-centred care serves as an integrated approach that produces tailor-made treatment plans (UMCG, 2010, n.d.). The intended improvements of the treatment of vulnerable elderly patients are fed into the education and training of future healthcare professionals (UMCG, 2010, p. 15). The UMCG is committed to the continuous learning and development of healthcare professionals. Therefore, the safety and quality of the care are cultivated by Clinical Governance (UMCG, 2014a). Clinical Governance focuses on developing five main elements of healthcare professionals' competences: thinking and awareness of the care processes, teamwork in multi-professional teams, open and appreciative communication, leadership based on trust, and ownership of the quality of care (UMCG, 2014a, p. 25; 2014b, pp. 7, 43).

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38 The established categories of competences in the nursing curricula are professional values and role of nursing, clinical practice, nursing skills and interventions, communication and interpersonal skills, as well as leadership, teamwork and management skills (Ten Hoeve, 2018, p. 12).

39 UMCG is an academic teaching hospital that was established in its current organisation in 2005, although the history of the establishment dates to 1797 (University Medical Center Groningen, n.d.).

40 The research into healthy ageing is connected to the Institute of Healthy Ageing. Together with the University of Groningen and Hanze University of Applied Sciences Groningen, the UMCG has established a knowledge cluster *Healthy Ageing Network Northern Netherlands (HANNN) – Region of Knowledge and Development* (University Medical Center Groningen, 2010, p. 3). Furthermore, the UMCG has a specialist unit for treating vulnerable geriatric patients: The Center for Geriatric Medicine.

2.2.2. *Long-term nursing home care in the Netherlands*

Currently, over 260 000 people in the Netherlands have dementia (Government of the Netherlands, n.d.-a; Koenders, n.d.). However, in line with the findings of the WHO (2015) (see section 1.1), an investigation by the Dutch Health Care Inspectorate (IGJ) revealed that there is a disbalance between the skills, knowledge and availability of nursing home caregivers and the actual care needs of the residents (Government of the Netherlands, n.d.-b). The disbalance has to do with the rising average age of people moving into nursing homes, which results in older residents needing more intensive and complex care. Also, new generations of elderly people have more specific preferences and expectations of the care provided to them (ibid.).

Subsequently, the Dutch government (ibid.) has implemented guidelines to improve the quality of nursing home care to enhance the well-being of people with dementia in the Netherlands. The plan of action, which was implemented in 2017 measures the following aspects of care: first, caregivers are called out to provide compassionate person-centred care with an appropriate professional stance towards the work. Second, the education and training of the caregivers must meet the demands of professional practice. Third, the level of transparency about the quality of the care must increase the public information about the operating nursing homes. Fourth, all residents with or without dementia living in nursing homes (or their guardians) must have a right to control the decision-making of the care plans to live a dignified life.

The Dutch government (n.d.-b) formulates that the person-centred principles of compassionate, respectful and dignified long-term care should be met in every nursing home in the Netherlands. Nursing homes that currently provide substandard care are provided increased support to meet the standards of the national guideline (ibid.). Many care facilities, however, still struggle to reach the goals due to regulatory issues or problems in the culture of the care unit.

2.3. A closer look: Meaningful Music in Healthcare and Music and Dementia

As explained earlier, this research focuses on two participatory music practices in two distinctive elderly care contexts in the Netherlands. First, in the context of short-term care, the research was conducted into the new explorative live music practice Meaningful Music in Healthcare (MiMiC) on three surgical hospital wards of the University Medical Center Groningen (UMCG) in the Northern Netherlands (2016-2017). Second, in the context of long-term care, the research was conducted on the established participatory music practice Music and Dementia in three separate nursing homes in three areas in the Netherlands: Purmerend in the province of Noord-Holland, Hoogkerk in the province of Groningen and Rotterdam in the province of Zuid-Holland (2016-2019). The following sections, 2.3.1 and 2.3.2, describe the two researched music practices in their respective contexts.

2.3.1. Meaningful Music in Healthcare (MiMiC) – music for hospitalised elderly people and nurses

2.3.1.1. Background

The first empirical study of this research focuses on what person-centred music-making can mean for the learning and well-being of nurses working in surgical hospital wards. In these wards, the nurses in question give care to a high number of elderly surgical patients. As previously explained, in order to find out "what music actually 'moves' in hospital settings" (see Smilde et al., 2019, p. 14), a research project "MiMiC" was carried out at the UMCG between 2015-2017. The research project was joint between the researchers of the research group Lifelong Learning in Music (LLM) of Hanze University of Applied Sciences Groningen and the researchers of the department of surgery of the UMCG (Smilde et al., 2019) and it involved three PhD-fellows – myself included. The outcomes of the joint research were presented in a symposium "Meaningful Music in Healthcare" on December 8th, 2017 at Prince Claus Conservatoire in Groningen and in a book "If Music be the Food of Love, Play On" two years later (see Smilde et al., 2019).

The qualitative research carried out by the LLM-researchers focused on the social situations of the live music sessions in the hospital wards with three perspectives: first, what kind of learning took place for the musicians working in the practice; second, what the interactive music sessions meant for the well-being of healthcare professionals (contributed by this very PhD research); and third, how the musicians interacted with the patients and nurses within the new context of work (Smilde et al., 2019). The UMCG-researchers examined the physical well-being of elderly patients who took part in the music sessions[41]. The findings on the impact of live music of the MiMiC sessions on the patients' pain perception have been encouraging (see Smilde et al., 2019).

During the joint research into MiMiC, six explorative pilot projects took place in three surgical wards: Abdominal and Oncological Surgery, Traumatology, and Vascular and Hepatobiliary Surgery in 2016-2017. During this time, the data collection for this PhD research was carried out (see section 4.4) in connection to the MiMiC research project. Before beginning data collection, I visited two of the three wards: Abdominal and Oncological Surgery (9 – 15 November, 2015) and Traumatology (3 – 9 December, 2015) as a musician during two *pre-pilots*. The pre-pilots, each seven-days-long, were necessary for gaining a primary contextual familiarisation of the hospital environment so that the practice could be developed, and data gathered. In two of the six MiMiC research pilot projects in 2016-2017, I participated again as a MiMiC musician, and in four of the six pilot projects, I collected data as a researcher and participant-observer with a specific focus on the healthcare professionals' participation and interactions with patients and musicians in the music sessions (see section 4.4).

Although the well-being of the patients and the learning of the musicians were central in the MiMiC research, as well as the development of new professional practice for musicians and a new training module 'Music and Healthcare' for music students in higher

41 The researchers of the UMCG conducted measurements and quantitative questionnaires before, during and after the music session to find out if the music helped the older patients' perception of pain, stress or anxiety (Smilde et al., 2019).

music education, these foci are intentionally left out of the framework of this PhD research. This PhD research focuses exclusively on the learning and occupational well-being of healthcare professionals participating in the MiMiC and the Music and Dementia practices with vulnerable elderly people.

2.3.1.2. Description of the practice Meaningful Music in Healthcare (MiMiC)

In the ongoing MiMiC practice, each six-day-long[42] participatory music project consists of tailor-made interactive live music sessions that are integrated into the day structure of the hospital ward. One daily session is 60-75 minutes long depending on the day structure of the ward. During that time, three professional musicians make music with and for the patients and nurses in the patient rooms, waiting room of the ward, and in the nurses' breakroom. Although focusing on the well-being of older adult patients in particular, the MiMiC practice is inclusive to all adult patients of 18-100 years of age in shared and individual hospital rooms (Smilde et al., 2019). The patient encounters are facilitated by a *mediator*, who functions as a link between the musicians, the healthcare professionals and the patients. The mediator makes sure that the music is brought to everyone who wants to hear it and schedules the sessions so that the musicians can focus entirely on their interactions with the patients and the nurses (ibid.).

Each MiMiC session begins with a daily brief by a coordinating nurse. During the meeting, the musicians learn which patients are expecting the visit, and also, which patients are unable or unwilling to have the music. Also, the musicians learn about how hectic the ward is each day, which informs them to adjust their expectations of staff participation in the music sessions. After the brief, the musicians greet the nurses in their breakroom.

The musicians play a selected piece of music for the nurses that is often linked to a meaningful moment with a patient the previous day. This way, the musicians feed information about the processes in the music sessions back to the nurses, who may have been unable to join due to their workload. The length of the visit in the nurses' breakroom depends on the situation at the workplace (e.g. hectic or calm, under-staffed or average-staffed). At times, the musicians take part in the nurses' birthday celebrations in the breakroom, play congratulatory music or ask the birthday person to conduct them as a celebratory means. What is important to note about the nurses' breakroom visit is that the musicians play specifically for them instead of their patients at that very moment.

After the music in the breakroom, one of the musicians plays on the corridor of the hospital ward to signal to the patients about the start of the session. Then the mediator guides the musicians to the rooms of consenting patients. Each session is built upon approaches of *person-centred music-making* (Smilde et al., 2019). These approaches include improvised music that is created specifically for or with the person(s) *in the moment*, as well as a diverse selection of repertoire of various genres (ibid.).

During the musical visits in the patients' rooms, the musicians take the patients' condition into consideration when fine-tuning their musical approaches. The musicians may ask the patient – and her/his nurse if present – to describe, e.g. a landscape, a colour or

42 Initially, the MiMiC projects were designed to consist of seven days. However, it became clear that a project of seven consecutive days was too long for musicians to maintain a preferred energy level in the music-making. Thus, the last three pilot projects were cut down to six days of work, which is now the standard length of a MiMiC project.

a mood, which can be translated into music. The patients may also tell stories, sing along or conduct the musicians with a baton in the co-creative musical moments. The musicians play a piece, for example, by Bach, a song by Elvis Presley or improvise in the style of either one of the two – depending on the needs of the patient. Each encounter usually lasts between 10-15 minutes per room. During that time, the musicians interact with individual patients or groups of patients sharing a room and their nurses.

Each MiMiC session ends with a debrief with the coordinating nurse to hear the immediate responses from the patients and nurses, and to make a plan for the next session on the following day. Finally, the mediator sends a short description of the day via email that reaches all healthcare professionals of the ward every day of the project. The description aims to spread new insights and share meaningful processes from the music session with the whole work community.

2.3.2. Music and Dementia – music for elderly people with dementia and their caregivers

2.3.2.1. Background

The second empirical study of this PhD research focused on the established participatory practice of Music and Dementia. Music and Dementia consists of interactive creative music workshops designed and transferred into the Dutch nursing home care context through research into the Music for Life practice (see Smilde et al., 2014). Music for Life was earlier described in the forestudy of this dissertation (see sections 2.1, 2.1.1). Based on the research of Smilde et al. (2014), a training module 'Music and Dementia' was created in the conservatoires of Groningen and The Hague to educate and prepare novice musicians for the professional practice.

The research of Smilde et al. (2014) suggests that the Music and Dementia practice can create a sense of intimacy, collectivity and belonging that is shared by participating residents and caregivers. These elements arise from the musical approaches that promote togetherness, autonomy and a *genuine personal contact* in the moment (Dons & Smids, 2014). Most significantly for this PhD research, the previous findings of Smilde et al. (2014) suggest that caregivers may engage in valuable learning processes in the music sessions. First, discovering the benefits of the shared music-making for residents, and second, gaining new insights into the residents and the musicians' ways of interacting with them. These aspects can spark reconsiderations of how the caregivers are approaching their daily care work (ibid.). Since the publication of the research outcomes in the symposium "While the Music Lasts" on June 6th, 2014 in Amsterdam, the practice Music and Dementia has been rolled out in the Northern Netherlands, the regions of The Hague and Amsterdam, as well as in the province of Friesland.

In this second empirical study of this PhD research on Music and Dementia, the focus was on the learning and well-being of nursing home caregivers participating in the music sessions. Data collection of the Music and Dementia practice took place between 2016-2019 (see section 4.4) by observing three Music and Dementia projects that were run by two Dutch organisations providing live music projects in various healthcare contexts.

PROJECT 1 IN PURMEREND, NOORD-HOLLAND

The first of the three observed projects took place at a nursing home in Purmerend in the province of Noord-Holland between 18 January - 7 March, 2016. The nursing home offers residential care and domestic assistance. The home is managed by De Zorgcirkel that is an elderly care organisation specialised in the areas of living, well-being, services, care, treatment, and illness prevention. The long-term residents of the nursing home often need intensive and specialised care. Person-centred care with individual attention to the residents is named as a core aim of the organisation's cooperative principles. See www.zorgcirkel.com.

PROJECT 2 IN HOOGKERK, GRONINGEN

The second observed project took place at a nursing home in Hoogkerk in the province of Groningen, between 14 October - 6 December, 2017. The nursing home where the project was carried out is part of the care organisation Dignis. Dignis offers long-term care for people in nursing homes and those who still live at home in the region of Groningen and North-Drenthe. The nursing home provides various forms of supported living: independent home living in apartments with care in the neighbourhood, independent assisted living within the nursing home building, residential living for people with dementia, as well as short-term living for people recovering from medical procedures. The observed Music and Dementia project took place in the residential living unit of a nursing home. See www.dignis.nl.

PROJECT 3 IN ROTTERDAM, ZUID-HOLLAND

The third observed project took place at a nursing home in Rotterdam in the province of Zuid-Holland between 16 November, 2018 – 15 January, 2019. The nursing home is operated by the organisation Laurens. Laurens provides elderly care in the area of Rotterdam for individuals who need home care, rehabilitation, nursing home care or palliative end of life care. The nursing home where the observed Music and Dementia project took place, offers residential nursing home care. See www.laurens.nl.

2.3.2.2. Description of the practice Music and Dementia

A standard Music and Dementia project is structured by an eight-week period of one-hour-long weekly music sessions. In each session, three musicians, one of which is a workshop leader, use *person-centred improvisation* as a catalyst for communication on various levels (see section 3.2.5). According to Smilde et al. (2014), person-centred improvisation is a form of music-making that aims to communicate meaningfully with the participants of a music session and acts to engage them in the musical processes. The music of person-centred improvisation aims to authentically reflect and resonate with the participants' musical needs[43] (ibid., p. 16).

43 A similar, but extended approach *person-centred music-making* is used in the MiMiC practice (see Smilde et al., 2019).

In the Music and Dementia project, eight participants with dementia and three caregivers join the musicians in a circle-setting, where the music-making takes place. Outside the circle, there are places for observers (e.g. other staff members, project manager, family members, researchers). Each session begins and ends with a *framing piece* (Smilde et al., 2014) which forms a ritual that builds familiarity about the structure of the session for the participants. The same pre-composed framing piece is used across all sessions. Thus, the participants are able to sing along to the familiar, repetitious melody during the progression of the sessions. After the framing piece, a *welcome song* follows (ibid.). In the welcome song, all participants are sang-to by the workshop leader and greeted by their names. It is a moment that allows everyone in the circle to be personally acknowledged and to have a moment to respond to the workshop leader according to her/his capabilities and resources at the very moment (ibid).

The person-centred improvisations that fill the majority of the session time are pieces of musical dialogue between a resident or a group of residents, the caregivers and the musician(s). The *passing instruments activity* (as described in Smilde et al., 2014, p. 30) can include percussion instruments[44] that the resident is invited to play. The musicians then accompany her/him by responding sensitively to the signs of the music-making. At times, a resident and a caregiver may create music together or a group of residents might play together with the musicians. At other times, a resident may conduct the musician(s) with a baton. The musicians may also play so-called *musical islands* or *island pieces* (Smilde et al., 2014, p.191), which have the function of re-connecting the musicians as an ensemble. The island pieces also give structural support to the music-making, which facilitates collective playing with the whole group of participants. At the end of the session, the musicians play the framing piece again to conclude the session.

The workshop sessions aim to enhance the relationships between the residents and the caregivers (Dons & Smids, 2014). Smilde et al. (2014) suggest that the caregivers' participation in the practice can lead to meaningful learning that stems from the experiences of the music sessions and reflection thereafter. By observing the processes of musical interactions between the musicians and residents in the music sessions, the caregivers may see new sides of the people to whom they give care in the everyday care delivery (ibid.).

After each session, the musicians have a moment to evaluate the music-making and plan the approaches for the following session based on the interactions that happened in the circle. Furthermore, the musicians and the caregivers share a reflective debrief session, where they look back on the interactions and responses of each resident towards the music-making. This reflective debrief session is seen as a crucial element for supporting the professional development of the musicians and the caregivers. The caregivers also share their experiences with other staff members who either co-participate in the music project or not. The project can, then, become a shared experience within the whole community of caregivers. However, it is important to mention that the Music and Dementia practice in the Dutch long-term care context does not include the formal staff development programme as in the Music for Life practice in the UK (see section 2.1.1).

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44 The list of appropriate instruments includes tuned and un-tuned instruments, such as chime bars, shakers, kalimba, African rattles, various drums (e.g. djembe, frame drum, ocean drum), cabasa, claves, guiro, maracas, tambourine, and rain stick. See the full list in Smilde et al. (2014, pp. 298-301).

3. CONCEPTUAL AND THEORETICAL FRAMEWORK

3.1. Experience: Learning through action and reflection

3.1.1. Philosophical pragmatism: the interest of knowledge in the research

The theoretical framework of this research builds upon the empirical pragmatic epistemology that makes *experience* the focus of what needs to be described and interpreted. It also has a holistic view of knowledge, meaning that knowledge comprises of the person's whole "affective, intuitive, thinking, physical, spiritual self" (Yorks & Kasl, 2006, p. 46). Thus, the core of the theoretical and conceptual framework draws primarily on John Dewey's[45] philosophical pragmatism that focuses on learning in environments that foster experiences, interaction and communication (Westerlund, 2004; Renshaw, 2009).

Philosophical pragmatism aims to understand the meaning of experiences as *anticipated consequences* of actions (Elkjaer, 2009, p. 76). Pragmatism sees the learner as an active and future-orientated agent in a learning *situation*[46] which involves both anticipatory and reflective processing: anticipating future actions, as well as reflecting upon past actions and upon oneself *acting* (Elkjaer, 2009, pp. 77-78). Caldwell (2012) emphasises that the capacities of future experiences are defined, engaged with, and explored within the context of present experiences (p. 44).

Actions are interactive, purposeful and continuous processes, where the actor selects relevant stimuli to which they respond (Smilde et al., 2014, p. 36). In the pragmatic enquiry of knowledge, however, experiences are not only had[47], but they are also used as "tools to think with" in "an instrumental way" (Elkjaer, 2009, p. 75). Subsequently, philosophical pragmatism considers thinking[48] as an instrument for solving problems that arise from experiences encountered through interactions in social situations. Consequently, knowledge becomes "the accumulation of wisdom that such problem-solving generates" (Westbrook, 1999, pp. 2-3).

3.1.2. Principles of continuation and interaction underpinning experiences

As explained, the core of Dewey's[49] pragmatism is *experience*. Experience, as Dewey defines it, is both the process of *experiencing* and the outcome of those experiences. Experiencing is

45 John Dewey (1859-1952), an American philosopher, has been recognised for the significance of his notions of democracy, freedom and the integration of theory and practice in education (Westbrook, 1999). He is considered as an educational reformer (ibid.).

46 In Dewey's terms, a *situation* encompasses the internal and external elements that constitute an experience (Dewey, 1938/2015., p. 42; Caldwell, 2012, p. 53).

47 In Dewey's writings, the word *having* an experience refers to the processes of experiencing. Having *had* an experience relates to the processing of past experiences, which can lead to new possibilities of learning and knowing (Dewey, 1934). Dewey does not suggest that *having* should be associated with *possessing* in any way.

48 Dewey (1916/2009) defines thinking as "the intentional endeavor to discover specific connections between something which we do and the consequences which result, so that the two become continuous" (p. 114).

49 Dewey's notions on experience and learning are described in his works, e.g. *How We Think* (1910), *Democracy and Education* (1916), *Art as Experience* (1934), *Experience and Education* (1938).

"characterized *more* by the interplay of doing and being-done-to, or the interaction of actors and the responses from others and environments, than by purely rational or intellectual operations" (Caldwell, 2012, p. 49.).

There are two chief principles of experiencing in Dewey's philosophy. The first is the principle of continuity and second is the principle of interaction. The two are interconnected, which means that in a learning situation, the external conditions impact the learning process (principle of interaction), which happens in a *continuum* of past, present and future experiences (principle of continuity) (Dewey, 1938/2015, pp. 46-47).

The principle of continuity implies that experiences are cumulatively and sequentially integrated. Dewey (ibid.) argues that every past experience impacts the quality of the future experiences (p. 37), because what is learned becomes "an instrument of understanding and dealing effectively with the situations which follow" (p. 44). Dewey (ibid.) refers to the continuous experiential development of knowledge as *growth* or *growing* (p. 36).

When it comes to the principle of interaction, Dewey (1938/2015) states that an experience is a 'transaction' between the individual and their environment that is "whatever conditions interact with personal needs, desires, purposes, and capacities to create the experience which is had" (pp. 43-44). Dewey (1938/2015) argues that "every genuine experience has an active side which changes in some degree the objective conditions under which experiences are had" (p. 39). This last statement suggests that by the principle of interaction, learning experiences have a potential to create change not only in the learner's processes of growth but also in the environment that serves as the situation of growing.

3.1.3. The epistemology of experiencing: a pragmatic view on learning and knowledge

To put it simply, pragmatism considers learning from experience as establishing a relationship between the experience that is had and what happens as an outcome of said experience (Caldwell, 2012, p. 48). Thus, learning is considered to be grounded in the interplay of action and thought (Dewey, 1916/2009). In epistemological terms, Dewey suggests that knowledge is not the primary purpose of experiences because all experiences have some form of knowing in them. Instead, Dewey (1916/2009) recognises all continuous actions (non-cognitive or conscious) as experiencing, and therefore, becoming knowledgeable should be seen as part of experiencing rather than as an end result.

Pragmatism recognises both the active learning processes of *experimental responsiveness* and the habitual (non-cognitive) actions and knowing (Elkjaer, 2009, pp. 77-78). In other words, Dewey (1916/2009) suggests that experiencing is either active trying or passive undergoing during an activity. In fact, Dewey (1916/2009) makes a distinction between knowledge (*knowing that)* and habitual knowing (*knowing how)*. Polanyi (1966) further explains that "people know more than they can tell" (p. 4). In line with Dewey's notions of knowledge, Polanyi (ibid.) makes a similar distinction between tacit *knowing-how* (expertise), and explicit *knowing-that* (viewpoints, beliefs, models etc.). According to Innis' (2015) analysis, these theoretical similarities between Dewey's and Polanyi's concepts of knowledge can be considered as significant parallels. Attaining wholly explicit knowledge is, however, unthinkable (Polanyi, 1966). Wenger (1998) agrees with this notion and adds that knowledge cannot be classified purely explicit or tacit because both aspects are always present in the learning situation (p. 69).

3.1.4. Meaning-making of an experience

When a person acts upon an experience or does something with it, "it does something to us in return" (Dewey, 1916/2009, p. 109). By this, Dewey means that experience as active trying encompasses change, but that change is meaningless unless the action is reflected upon. Dewey (ibid.) writes: "When we reflect upon an experience instead of just having it, we inevitably distinguish between our own attitude and the objects toward which we sustain the attitude" (p. 130).

During the process of reflection, there is tension and suspense of what is already known and what remains uncertain (Dewey, 1916/2009). Thus, a reflective process begins with a state of hesitation and doubt[50]. In a problem-solving situation, this tension leads to an anticipation of consequences and considerations on the basis of available facts and previous knowledge in order to find clarity on the issue at hand. Finally, from hypothetical ideas of a solution to the issue, a plan of action can arise to reach the anticipated consequence (Dewey, 1910, pp. 7-9; 1916/2009, pp. 116-118).

Furthermore, emotional experiences are central in Dewey's theorising of learning, as the process of meaning-making is often triggered by an emotional response to an unfamiliar or new experience. Also, Dewey (1938/2015) explains that experiential learning depends upon the perceived quality of the experience. Consequently, not all experiences lead to knowledge, as some never enter consciousness and communication: "Everything depends upon the quality of experience which is had. The quality of any experience has two aspects. There is an immediate aspect of agreeableness and disagreeableness, and there is its influence upon later experiences" (Dewey, 1938/2015, p. 27). According to Dewey (ibid.), experiences arouse curiosity and initiation of action, and the value of an experience "can be judged only on the ground of what it moves toward and into" (p. 38).

An experience that has *meaning* cannot be without reflection or thought, because "when an activity is continued into the undergoing of consequences, when the change made by action is reflected back into a change made in us, the mere flux is loaded with significance. We learn something" (Dewey, 1916/2009, pp. 109, 113). Caldwell (2012) adds that as an outcome of responding to new situations, the person adjusts their attitudes and habits so that they correspond "to needs in the stimuli of these conditions" (p. 52).

In a learning situation, meaning-making is a complex process that involves first-hand observation of external conditions. Second, it requires experiential knowledge about familiar situations in the past. Third, meaning-making requires a judgement about the significance of the situation based on what the observations and recalled information suggest (Dewey, 1938/2015, pp. 68-69). Finally, the meaning-making process may reach a satisfactory conclusion based on the judgement about the situation (Dewey, 1910, p. 79).

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50 Hesitation and doubt seem especially relevant for stimulating learning among healthcare professionals because nurses, in particular, are trained to work under fixed protocols of risk reduction and maximal certainty (see Youngson, 2012). Thus, in line with Dewey's (1916/2009) theorising, introducing an unfamiliar element of live music into the healthcare professionals' work environment may bring about uncertainty and doubt among the healthcare professionals, which may lead to meaning-making of the musical experiences and eventually, to new kind of learning.

3.1.5. The ontology and contextuality of experiences

The ontology of Dewey's concept of experiencing is associated primarily with human life and *living* (Elkjaer, 2009, pp. 74-75). Living, in line with Dewey's principle of interaction, is the continuous transaction between a learner and her/his environment. This transactional interplay is both experimental and playful in its character (ibid.).

On a contextual level, Väkevä & Westerlund (2007) note that in Dewey's pragmatism, the learner's experience is situated in a context of cultural practices, local rules, principles and traditions. In fact, Dewey characterises society as a living organism and stresses the significance of each individual's participation (Boon, 2009, p. 11).

Agency and experiences are, thus, developed in relation to shared actions, habits and practices (Caldwell, 2012). It means that the subjective and intersubjective dimensions of experiencing are integrated and thus, subjectivity cannot be separated from the sociocultural context and its conditions of learning (Väkevä et al., 2007). Dewey (1938/2015) endorses this idea with a statement that "all human experience is ultimately social" and involves contact and communication (p. 38). In summary, human life is seen as a series of consequential situations in Dewey's ontological theorising, where experiencing is a fundamentally social process and learning and interaction are inseparable from each other.

3.1.6. Experiencing through engagement with the arts

In Dewey's (1934/2005) philosophy, artistic engagement is a part of daily human life within the social world. Artistic experiences "occur in the realm of action and are very closely bound to social context" (Boon, 2009, p. 12). In Dewey's reasoning (1934/2005), artistic experiences have the potential to hold an *ideal* meaning and value, which can enhance the experience of everyday life and actions.

Dewey highlights the significance of imagination as a basic process of experiencing (Russell, 1998, p. 193). Dewey argues that the ability to imagine and creatively question "what – if" is needed for anticipating the consequences of actions (Elkjaer, 2009). It is especially relevant in situations where people are confronted with occurances that challenge their existing attitudes and habits (see also Caldwell, 2012).

In line with Dewey's reasoning, Turino (2008) writes that music can evoke 'iconic'[51] associative connections by stimulating imagination (p. 7). These musical icons can trigger imaginative experiences by the listeners and "awaken [them] from habit" (ibid., p. 17) within an interplay of "the Possible and the Actual" (ibid., p. 17). Turino (2008) states:

> "[…] the arts are a realm where the impossible or non-existent or the ideal is imagined and made possible, and new possibilities leading to new lived realities are brought into existence in perceivable forms. Art is not really an "imitation of life"; it […] [emphasises] the interplay of future possibilities with experiences and things we already know from the past – all within a specially framed and engrossing present" (p. 18).

Similar to Turino's (2008) notion of "new lived realities" above, DeNora (2000) explains

51 Turino (2008) explains that icons are associative connections between a piece of music and what it evokes in the listener (p. 7).

that musical engagement can function as an *agent* or a *technology* of self-production (DeNora, 2000, p. 46). The meaningfulness of musical experience allows music to serve as a container of and a reference to past experiences. Thus, the self can be found in the music (ibid., p. 69). DeNora (2000) explains that music is an "active ingredient in the organisation of self, the shifting of mood, energy level, conduct style, mode of attention and engagement with the world" (p. 61). Self-production through music is a continuous process that involves tacit knowing of oneself in social practices, where the self is presented to others (DeNora, 2000, p. 62; Hesmondhalgh, 2013). The way musical experiencing works towards constituting and maintaining the self is through reflexive practice that is rooted in interaction with the environment (ibid.). The music does not only have personal meaning for the individual, but it also *does* something to her/him (DeNora, 2000, p. 49; Hesmondhalgh, 2013, p. 117), which is in line with Dewey's principle of interaction and concept of meaning-making (see sections 3.1.2, 3.1.4).

Through *aesthetic reflexivity,* one becomes aware of the self as a subject to external demands set by the environment (DeNora, 2000). DeNora (ibid.) proposes that individuals experience problems with self-regulation when the tensions between external necessities and internal preferences create a conflict. Here, music can serve as a tool to help self-regulate in situations where *care for self* is needed (ibid., p.53). DeNora (2000) recognised that musical experiencing can impact the person's cognitive, bodily and self-conceptual states by, for example, enhancing or sustaining them. The knowing of what kind of music is needed to be experienced or avoided is part of an *often-tacit* practice of self-production (DeNora, 2000, p. 49).

DeNora (2000) suggests that music helps to get into a desired or out of an unwanted mood or state, because music's components, (e.g. rhythm) work as a representation of the desired end goal. Here, the pragmatic notion of anticipated consequence of actions seems fitting (see above section 3.1.1). Music that feels appropriate for generating change to a situation can create a *virtual reality*, where the individual can express their emotions and needs internally through the musical experiencing (DeNora, 2000, p. 56). DeNora (ibid.) writes: "For a few moments, the environment consists, virtually, of only music […]" (p. 56). Through the reflexively created virtual realm of musical imagining, the individual may be able to regain a sense of self-determination or control of her/his physical surroundings (ibid.).

3.1.7. The perception and value of artistic experiences

Philosophical pragmatism considers artistic experiences as active experiencing (Leddy, 2019). In the contemporary music education research, Elliott's (2005) praxialist argument on music as an activity that includes "a doer, some kind of doing, something done, and the complete context in which doers do what they do" (p. 40) seems fitting to this positioning. However, Väkevä & Westerlund (2009) note that according to a pragmatic view on music and its value for learning, as a part of human culture music can be considered as a living platform of interaction, where creative processes can be channelled to support the constructive processes of *growth* (p. 97). So, musical engagement can be seen as a factor for creating an impact on and change in the cultural community by opening *new horizons of meaning* (ibid., p. 97). Westerlund (2008) argues: "Hence, ideally, music learning is integrated into the stream of experiences that carry their voice throughout the learner's life, becoming

part of his or her self-construction" (p. 90). Subsequently, learning experiences may actively reconstruct the community and its culture (Väkevä & Westerlund, 2009, p. 97).

In terms of the perceived value of musical experiences, Väkevä & Westerlund (2009) explain that philosophical pragmatism emphasises that experiential musical processes are evoked by the dynamic, temporal transactions and interplay between the learner's *situational needs* and the collective cultural context (p. 99). Thus, the principle value of a musical experience is dependent on how the experience answers to the needs of the situation or the problem at hand (ibid.). In other words, philosophical pragmatism is concerned with what kind of possibilities the musical experiences can bring about, and what use they can serve. However, it is important to understand that the value of musical experiences is attached to the processes of experiencing, as well as to its (sociocultural) consequences (ibid., pp. 99-100). Subsequently, the 'doing' of music-making as an *intensifying experience* has intrinsic value beyond the instrumental value of the musical activity itself (Westerlund, 2008, pp. 82-83.). Westerlund (ibid.) explains: "Dewey's concept of a means-ends continuum guides the reflective imagination to work on how and under which conditions music becomes a constitutive element of the learners' good life and not just on how music is good *for* their life" (p. 90).

3.2. Participation: Learning within a community of practice

3.2.1. Participation in the workplace: agency and co-participation

Understanding and improving work engagement, vocational performance and occupational well-being, as well as promoting positive changes in various working cultures are prominent discourses in the field of workplace learning (Fenwick, 2010). Yet, the terminology of what is meant by learning in the workplace is rather vague (ibid.). As said, this PhD research views learning as an accumulation of experiences through participation in social interaction (see previous section 3.1.1). Participation is a wide term that, in the workplace context, encompasses the joint action of a group of practitioners sharing a professional identity, tasks and environment (Fenwick, 2010, p. 83). When referring to participation as something that recognises the individual's biographically connected learning processes within the collectively shared work community, it is beneficial to use the concept of *co-participation* (Billett, 2004; Fenwick, 2010). The concept of co-participation gives focus to the individuals' "conceptions, agency, intentionality, energy and interest in participating and learning through the workplace" (Billett, 2007, p. 62).

The notion of co-participation at work proposes, furthermore, that participation, engagement and meaning-making of new experiences are *relationally interdependent* (Billett, 2004) between the individual's identity and the collective practices in the workplace. Fenwick (2010) notes that the concept of co-participation – when considered as a definition for participatory learning at work – proposes that learning is stimulated by particular individuals, events, or conditions (p. 85). This PhD dissertation is interested in finding out how participatory music practices can prompt learning in the workplace by introducing music-making with professional musicians and patients or residents as particular events in the learning community.

Agency determines how co-participants engage in their work practice (Billett, 2001; 2002). Agency roots the co-participants' actions in a *temporal* and *contextual* framework, which is again in line with Dewey's principles of continuity and interaction of experiencing (see section 3.1.2). The American sociologists Emirbayer & Mische (1998) offer a brief definition for agency as a:

> "temporally embedded process of social engagement, informed by the past (in its habitual aspects) but also oriented towards the future (as a capacity to imagine alternative possibilities) and towards the present (as a capacity to contextualise past habits and future projects within the contingencies of the moment)" (p. 963).

Agency is characterised as a social process in a "collectively organised context of action", in which co-participants engage with each other during a given time (Emirbayer & Mische, 1998, p. 974). As such, the concept of agency is intrinsically social and relational. According to Emirbayer & Mische (ibid.), agency "centres around engagement (and disengagement)" with the environment (p. 973). This notion is in line with Dewey's concepts of the contextuality of experiencing (see section 3.1.5). The pragmatist view on experiential learning acknowledges the agent's anticipative and *deliberative attitude* in the context of action (see also Mead, 1932/2002, pp. 97-98).

In line with Dewey's principles of continuation and interaction, agency allows the agent to respond and adjust her/himself to the new situations in an imaginative (future) and a reflective (past) way while the present moment is emerging (Emirbayer & Mische, 1998, p. 1012). Aligned with the pragmatic view on learning, agency is always agency *towards* something (ibid.). Therefore, it has reconstructive and (self-)transformative potential when actors are faced with new or challenging circumstances (ibid.). Thus, agency may also create change in the social structures of the context of the action (Emirbayer & Mische, 1998, p. 970; Kristiansen, 2014, p. 22).

3.2.2. The social situatedness of learning

As proposed in the previous section 3.2.1, learning in the workplace happens through (co-) participation in a social practice, where agents and their environment are in constant interplay. Looking deeper into the situational and contextual aspects of learning at work, Lave & Wenger (1991) introduce a theory of *situated learning*. The theory focuses on what kind of social engagement provides a context for learning to take place, rather than on the cognitive or conceptual structures of learning (ibid., p. 14). In the situated learning theory, learning is seen as a process that primarily takes place in a *participation framework* instead of in an individual mind, and it is distributed between co-participants (ibid.). Lave & Wenger (1991) highlight that "there is no activity that is not situated" (p. 33). Learning is, therefore, an integral part of generative social practice in the lived-in world (ibid.).

Learning as participation involves the ability to *negotiate meaning*. Meaning is not a pre-existing judgement, but instead, it is constructed together within a group of social co-participants: "It entails both interpretation and action" (Wenger, 1998, p. 94). As such, the negotiation of meaning combines engagement and imagination into collective reflective practice (Wenger, 1998; Smilde et al., 2014, 2019).

Meaning is socially negotiated by the persons-in-activity and thus, knowledge is socially constituted and mediated in *communities of practice* (Lave & Wenger, 1991). Wenger explains that "communities of practice are a context for new insight to be transformed into knowledge" (1998, p. 214). Wenger (1998) specifies that a community of practice consists of four elements: *meaning* (the human ability to experience life), *practice* (the social resources and frameworks that sustain mutual engagement in action), *community* (social formations of *belonging* in which participation takes place), and *identity* (learning processes that create change and personal histories of *becoming* in the community context) (p. 5). The emergence of a community of practice is not dependent on the homogeneity of its members. Instead, some communities of practice are composed by individuals who represent different disciplines or functions (Wenger, McDermott & Snyder, 2002).

A community creates a *social fabric of learning*, where the members' willingness and commitment to sharing new ideas and insights with each other fosters collaborative learning (Wenger et al., 2002, p. 28). Wenger et al. (2002) explain that the emergence of a community of practice does not always happen without disagreement, but mutual respect, trust and safety are necessities for its development. For example, the rules of the common practice must be clear to all participants.

Communities of practice are *places of belonging* and characterised by participation and membership (Smilde et al., 2014, p. 24). To belong to a community of practice, one must feel welcome and respected and have a legitimate voice in the group (ibid.). Communities of practice have no centre or a core, but instead, they foster different types of participation between *newcomers* and *old-timers* (Lave & Wenger, 1991, p. 57). The newcomers often begin their process in a community of practice as *legitimate peripheral participants* and may grow to become *full* or *central* participants like the old-timers (Lave & Wenger, 1991). The recognition of learning as legitimate peripheral participation means that "learning is not merely a condition for membership but is itself an evolving form of membership" (ibid., p. 53).

Legitimate peripheral participation in the workplace develops professionally skilled identities in practice and may also transform the community of practice (Lave & Wenger, 1991, p. 55). Yet, legitimate peripheral participation may not always develop into full participation, as "the idea of identity/membership is strongly tied to a conception of motivation" (ibid., p. 122). Although legitimate peripheral participation implies an empowering potential for participating more fully, staying on the outside boundaries of or being unable to access the *legitimate periphery* of the practice can be disempowering (ibid., pp. 36-37; Wenger, 1998, pp. 119-120). Therefore, in Wenger's (1998) words:

> "[newcomers, who are not yet] on a trajectory to become full members […] [need] various forms of casual but legitimate access to the practice without subjecting them to the demands of full membership. This kind of peripherality can include observation, but it can also go beyond mere observation and involve actual forms of engagement" (p. 117).

3.2.3. Participation as becoming: the relational processes of professional development

Further relevant pragmatic concepts of participation as social interplay are drawn upon Mead's (1934/2015) *Mind, Self & Society*. Mead calls the *self* a reference point to all events,

emotions and sensations of a human experience (ibid., p. 136). The self is always a social self, meaning that a person's identity develops through social experiences and activities (Mead, 1934/2015; Smilde, 2016). Mead (1934/2015) explains: "The self […] arises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process" (p. 135).

There are two sides of the self: the *I* and the *Me.* Smilde (2016) explains that in Mead's terms, both of them are distinctively part of a social interaction: "the "I" is the direct utterance of the self, acting and reacting, the "Me" is the social self, the self that is aware of others and that views itself through the eyes of others" (p. 310). According to Mead's philosophy, all actions need to be viewed in relation to the social processes with other individuals (Stryker, 2008, p. 17), because individuals are connected to other individuals through their social selves. Mead (1934/2015) states: "Selves can only exist in definite relationships to other selves. No hard-and-fast line can be drawn between our own selves and the selves of others […]" (p. 164).

Furthermore, Mead suggests that social institutions are significant for the maturation of individual selves and personalities (ibid.). Mead's concepts of *generalised social attitudes* and the *generalised other* (ibid., pp. 260-262) propose a strong interrelation of social standpoints between members of a community (of practice). In Mead's (ibid.) terms, it is the social community that eventually gives "the individual his unity of self" because "the attitude of the generalised other is the attitude of the whole community" (p. 154). As an outcome of the generalised other, individuals view themselves through the eyes of the people in their social organism and adjust their behaviour to fit its generalised attitudes.

The notion of the generalised other is especially relevant in this research, because the research participants are healthcare professionals. Healthcare professionals are known to have highly developed professional identities (Ten Hoeve, 2018). Ten Hoeve (2018) writes that nurses develop shared professional identities that are reinforced through workplace relationships, work experience and various contextual impacts therein (p. 10). The cornerstones of the nurses' shared professional identity are the generalised values and beliefs that guide the nurses' actions and interactions within the care practice (ibid., p. 39). The development of the professional identity is tied to one's self-concept and personal values that are interconnected with the joint professional identity of the members of the community of practice (Lombarts, 2010, p. 16; Ten Hoeve, 2018, p. 11).

Social experiences with patients and colleagues are crucial factors for developing nurses' professional identities (Ten Hoeve, 2018., p. 128). Benner (1984/2001) adds that through the development of professional expertise, nurses learn *common meanings* of the profession that build the culture or tradition of nursing, as well as *sets of assumptions* and expectations towards various situations in the professional practice (pp. 6-7). These developments lead to a value system and judgements of, for example, what is the appropriate emotional distance between oneself and the patients, or what can be considered as suitable clothing to wear at work (Lombarts, 2010, p. 16).

3.2.4. Workplace participation as a performance of the self

When it comes to the face-to-face domain of interaction, Goffman's[52] micro-sociological

52 Erwin Goffman (1922-1982) is considered as one of the most influential sociologists of the twentieth century. His contributions have led to the development of the so-called 'sociology of the everyday life' (Henry, 2016). In his

analysis of social interplay in public and private settings, as well as in one-to-one and group situations, applies to this research, which focuses on experiential learning in participatory music practices. Goffman's (1983) notion of an *interaction order* serves as a basic unit for viewing socially situated interactions. When individuals come into each other's immediate *response presence* (Goffman, 1983, p. 2), the nature of their interaction can be characterised by the following metaphoric aspects: drama, ritual and game (Henry, 2016).

The drama metaphor applies to the individuals' need to control the impression that the others receive of them; the game metaphor refers to the possibilities of winning (e.g. praise, recognition) or losing (e.g. embarrassment), and the ritual metaphor refers to the interactions and behaviours that are repeated in order to maintain social order (ibid.).

There is a *social framework* underpinning the interaction order (Goffman, 1974; 1983). The social framework means that although each participant may have a different perception of the social situation, the interaction can still be coherent if there is enough mutual understanding of it between the co-participants. In addition to Dewey, Mead, and Lave & Wenger's previously described theorising on interaction and learning, Goffman's micro-analysis considers the self as socially constructed through mostly unspoken rules, rituals and routines of social interplay (Henry, 2016). The construction of the self is divided into the *self-as-performer* that feels e.g. embarrassment and thus, aims to maintain an appropriate impression to others, and *the self-as-character* "out of which the socialised self […] emerges" (Henry, 2016, p. 162). There are, hence, parallels between Goffman's (1959/1990) and Mead's (1934/2015) concepts of a 'social self' responding to and adopting the generalised norms and attitudes of others.

Goffman (1959/1990) offers further notions about the mechanisms of social interaction within the interaction order; *setting*, *stage*, *impression management***,** *teams* and *performance*. A person's agency in a social situation where they interact with others can be called a *performance* (ibid., p. 32). The person as a performer aims to control the impression s/he gives off to the others by managing the attributes of the character s/he portrays (see again *self-as-performer* above) (ibid., p. 26).

Impression management is crucial to avoid giving off a 'false impression' that could threaten the relationship between the performer and the audience (Goffman, 1959/1990, p. 26). Therefore, individuals may attempt to stick to a role as carefully as possible to avoid acting 'out of character' (ibid.). The performer works towards convincing the audience that s/he possesses the appropriate attributes connected to the character s/he portrays (e.g. a nurse or a caregiver). Simultaneously, s/he relies on the audience or co-participants taking the performance seriously (ibid., pp. 26-28).

Professional distance is a relevant concept of participation in the field of healthcare, because maintaining distance is part of the impression management of the *front* that conveys the institutional norms of a professional performance (Goffman, 1959/1990, p. 32). Ten Hoeve (2018) points out that professional performance of nurses goes beyond the healthcare context and contributes to the public image of the profession (p. 42). It links to Goffman's notion that the performance serves mostly to express the qualities of the task being performed rather than the characteristics of the person performing it (1959/1990., p. 83). The tension of being simultaneously viewed as a performer and the character that one

work, Goffman has developed theatrical metaphors for describing social life and explaining human interaction (ibid.).

performs can be challenging for the individual's *self-production* in the social situation (ibid., pp. 244-245). This last notion aligns with DeNora's (2000) concept of self-production within the tension of external demands and intrinsic preferences (see section 3.1.6).

Performing continually is exhausting. Hence, a *back region* or *backstage* of the performance is an important space for self-production (Goffman, 1959/1990). The backstage is where the "stage props and items of personal front can be stored in a kind of compact collapsing of whole repertoires of actions and characters" (Goffman, 1959/1990, p. 114). On the backstage, in the absence of the audience, the performer can do things privately and adjust their personal front for the next performance (ibid., p. 116). On the backstage, the performer can relax, as s/he can 'drop the front', skip the expected lines, and step 'out of character' (ibid., p. 115).

Keeping the backstage hidden from the audience is a crucial part of impression management. Thus, when it comes to the professional performance, Goffman (1959/1990) argues that performers only begin to act when they are in the physical *setting* of the *frontstage* (p. 33). The setting consists of the physical layout of the *scenery*, such as a hospital ward, and *expressive equipment*, such as the nurses' uniforms (ibid). Some characteristics of a performer are fixed (e.g. age, gender, or race) but some vary from one moment to another (e.g. facial expressions) (ibid., p. 34). These aspects are called *appearance* and *manner* (ibid, p. 34). Goffman (ibid.) argues that on the frontstage of the performance, the audience expects that the appearance, manner and setting of the performance remain consistent.

Furthermore, pre-established *routines* are in place in the interaction order. Goffman (1959/1990; 1983) notes that in formal organisations, such as hospitals, routines and tasks are often connected to the hierarchical[53] status of the performer. Sometimes, an individual who is taking upon a new role may not know how to conduct her/himself in an unfamiliar situation. Thus, according to Goffman (1959/1990), the person goes through a process of "becoming at ease" with the new role (p. 30). During the time of the uneasiness, the individual is given *hints and clues*, or *stage direction* from the co-participants on how to carry out the role and adjust her/his repertoire of previous performances into the new setting (ibid., p. 79).

Some performances are firmly occupational. Thus, there is a professional etiquette that ritually preserves the *common front* of the profession (Goffman, 1959/1990, pp. 88, 95). In a work community, the co-participants can be seen as a performance *team*, meaning a group of people who cooperate "in staging a single routine" (ibid., pp. 85-86). Together, the team members are committed to the impression management of their team performance, which bonds them together and creates mutual dependence and a negotiated identity (ibid.).

When it comes to two separate teams encountering each other, e.g. musicians and healthcare professionals in the context of this research, their mutual interaction should be considered as a dialogue, where the teams present their team performances to each other (Goffman, 1959/1990, p. 97). The social setting in which the interaction between the teams

53 Studies suggest that social structures in the healthcare sector are hierarchical rather than flat (Youngson, 2012; Greham, 2012). Typically, in the hierarchy of hospitals, the hegemony of elite specialisation positions is furthermore occupied overwhelmingly by male physicians, whereas the nursing and caregiving professions are dominated by female workforce (Evans, 1997; Joyce, 2018). These caregiving professionals; nurses, care assistants, nutritionists, social workers etc., are known to work closely with the patients to deliver daily care (Bronner, Peretz and Ehrenfeld, 2003).

occurs is often 'hosted' or even managed by one of the teams. In this research, it can be seen that the healthcare professionals manage the setting of the encounter with the musicians as it takes place in their workplace. The music sessions, on the other hand, are hosted by the musicians who facilitate the musical processes and invite the healthcare professionals to co-participate in said processes.

3.2.5. Participatory music practices: engagement and interaction

Participatory music practices follow the tradition of *community music*[54] that is characterised by social engagement in a collective musical situation (see Renshaw, 2010). At its core, community music-making is a voluntary and participatory activity, where the musical interactions are seen to arise from the collective agency of a group of participants (Ansdell, 2014, p. 18; Matarasso, 2019, p. 39). Community music practices recognise musical participation as a social change agent and a means of social identity formation (Ansdell, 2014; Dunphy, 2018). The main notion of community music is that through shared musical participation, people are bound together as equal members of a community (Matarasso, 2019).

Community music can take various forms, but the aim is always to encourage collective and processual musical participation, promote equality and creativity, and reflect the context in which the music-making takes place (Murray & Lamont, 2012, p. 78). Turino (2008) argues that through musical participation, people can feel intimately part of the community: "Through moving and sounding together in synchrony, people can experience a feeling of oneness with others" (pp. 2-3). Subsequently, a group of participants can create a sense of *being together* through the shared musical experience (Turino, 2008, p. 43).

When it comes to facilitating musical interaction in participatory music, the main ethical concern is that all participation happens on a voluntary, equal and democratic basis (Lines, 2018; Matarasso, 2019). In participatory music-making, where the distinction between artists and an audience is downplayed to the minimum, the focus of the activity is primarily on the *musical doing* instead of its end product (Turino, 2008, p. 28). Thus, the quality of participatory music-making is judged based on "how the participants *feel* during the activity" (Turino, 2008, p. 29). Therefore, a core consideration of participatory music-making is that the community musicians are sensitive to the participants' experiences rather than focusing on their own (ibid., p. 29).

Inclusion of people with different abilities is a core value of participatory music-making (Turino, 2008, p. 31). Therefore, the community musician's ethical disposition as a facilitator is to be open and welcoming towards all participants with *absolute hospitality*[55]

54 Community music is an umbrella term for a variety of music practices emerging from outside institutionalised music education since in 1960's (Veblen & Waldron, 2012). Community music is a participatory activity that focuses on groups of people as communities (Ansdell, 2014, p. 18; Matarasso, 2019, pp. 19-20). The main concept is that the people belong to the community through musical activity that binds them together. There are five principles that give shape to defining community music practices: 1) the kinds of music and active music-making that happen 2) the participants 3) the intentions and aspirations of those involved 4) the teaching/learning practices, and 5) interplay between informal and formal social/educational/cultural contexts (Veblen & Waldron, 2012, p. 203).

55 The concept of hospitality by Derrida (2000) was applied in the context of community music by Higgins (2008, 2012) to explore the musicians' invitation, a 'welcome' to the participants to act together musically. Hospitality can be either unconditional (absolute) or conditional (see Derrida, 2000), and each 'welcome' carries the

(Higgins, 2008, 2012; Lines, 2018). It means "unconditional acceptance of a stranger, or other, regardless of their name and social standing" (Lines, 2018, p. 390). Lines (2018) adds that the work of the musician embodies *ethics of care*, meaning that the basis of the work builds upon the relation that connects the musical community, rather than on the actions of individuals (pp. 392, 398-399). For a community musician, the ethics of care require an attentive, receptive, responsive and caring stance to promote "love-in-action as a way of entering into relation-ships and caring for people" without assuming to know their needs (Lines, 2018, p. 393).

Participatory music practices in healthcare can be understood as a form[56] of community music. However, unlike conventional community music practices, participatory music practices in healthcare do not always involve music-making with groups of people. Rather, there can be one or more musicians in a participatory music project working with groups of people – patients, healthcare professionals and visitors – or just one person (Lilja-Viherlampi, 2012). Music can take the forms of listening, singing, playing together, improvising, moving to the music, or all of this, but it is always driven by a goal to find the right kind of music for the participant in the present moment (ibid.). Through the various forms of musical interaction, the music-making can become a landscape or an atmosphere where one can find enjoyment, refreshment or relaxation. Lilja-Viherlampi (2012) explains that the core of the work for professional musicians in healthcare lies in *interaction* that is embedded in reciprocity: giving, receiving and being received.

A key factor of participatory music practices in healthcare is that they promote a "non-hierarchical connection between patient and musician in contrast to the hierarchical relationship between patient and clinician or therapist" (Oakland, 2012, p. 3). Dons (2019) points out that "there appears to exist tacit consensus that co-creative artists act from a socially-engaged and person-centred stance *by default*" (p. 48). For example, Smilde et al. (2014) explain that *person-centred improvisation* "[…] consists of tuning in with a resident *and* oneself and can therefore be considered a musical metaphor for identity and connection, for I and Thou […]" (p. 90). Here the link to Mead's (1934/2015) theory of the social self is once again relevant, as person-centred improvisation can serve as a connector to 'the other' through the social self (see Smilde, 2016). Whether the person-centred musical approaches involve improvisatory music-making or a mixed approach including improvisation and carefully selected pieces of repertoire, the music aims to fit the person's musical needs and capabilities to engage in the moment (see also Smilde et al., 2019). Therefore, the music is brought gently, sensitively, respectfully and with 'open ears' (Lilja-Viherlampi, 2012).

In the hospital context, participatory music practices can optimally evoke creativity and shared joy as a window out of institutional realities (Bouteloup, 2010, p. 2). Yet, participatory live music practices are not used routinely in the medical environment of the hospitals, so healthcare professionals are likely not exposed to these practices (Preti

potential of unconditional and conditional hospitality (see Higgins, 2012).

56 The work of community musicians is traditionally characterised by project-work, workshops, performance events, and facilitation of musical participation in the social settings (Wood & Ansdell, 2018, p. 455). Since the late 1990's, however, community musicians have increasingly built their professional practices in care-related contexts such as nursing homes (Ruud, 2012; Preti & Welch, 2013; Matarasso, 2019), where the music practices are meant to promote collective engagement and well-being through musical participation and interaction (Smilde, Page & Alheit, 2014; Huhtinen-Hildén, 2014).

& Welch, 2012, p. 3; Chadder, 2019, p. 12). Preti (2009) found that nurses' participation in the music sessions depends on the "degree of tension in the ward and on the workload of the day […]" (p. 198). Furthermore, Preti (ibid.) discovered that during the music sessions, nurses seem more likely to relate to the musicians than doctors (ibid.). Holding a strict pharmacological view on health, especially, can increase detachment from and scepticism towards live music practices in hospitals (Chadder, 2019, p. 13).

In a study on healthcare professionals' attitudes towards live music practices in hospitals, Chadder (2019) found that above all, participation in the form of "watching a session in progress" or observing closely is an effective way of increasing nurses' openness and awareness of the musical processes (p. 6). Chadder (2019) sums: "perceptions improve with increased awareness" (p. 2.) Therefore, *establishing openness (*Micallef, 2015, p. 27) seems central for introducing participatory music-making in healthcare; especially, since healthcare professionals tend to perceive the music sessions to be solely intended for patients (Preti & Welch, 2012, pp. 8, 10). Furthermore, increasing communication between the musicians and healthcare professionals is crucial because, as Preti & Welch (ibid) suggest, healthcare professionals may struggle to fully recognise the musicians professionally, although valuing the musicians' expertise to engage and communicate with patients (p. 8).

3.3. Occupational well-being: Flourishing, emotions and presence

3.3.1. Broad definitions of health and well-being

In 1948, The World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2020). Since then, this definition has been criticised as it suggests that only people who are in a state of "complete well-being" are healthy, which leaves all other people categorised as "unhealthy" (Lases, 2017, p. 10). Later concepts have emphasised a person's own capabilities of maintaining good health through adaptation and self-management in the face of challenges (see, e.g. Huber, Van Vliet, Giezenberg & Knottrenus, 2013). Although health may be an essential component of well-being, it is not all that *being well* stands for (Crisp, 2017).

In 2015, the WHO defined well-being as "a general term encompassing the total universe of human life domains, including physical, mental and social aspects, that make up what can be called a "good life"" (p. 231). On the other hand, Nussbaum (2011) proposes a more specific *capabilities approach* to defining well-being by focusing on what a person is capable of *doing* and *being* (p. 20). The concept of *central capabilities*[57] refers to the absolute

57 The central capabilities according to Nussbaum (2011) are: life (being able to live to the end of a human life in its normal length), bodily health (being able to have good health), bodily integrity (e.g. being able to move freely without fear of assault), senses, imagination and thought (e.g. being able to use one's mind and one's freedom of expression), emotions (being able to have attachments), practical reason (e.g. being able to develop understanding and think critically), affiliation (e.g. being able to associate with others and have compassion), other species (e.g. being able to live with other creatures and enjoy nature), play (being able to laugh and have fun without being criticised), control over one's environment (e.g. being able to participate in political activities and being treated reasonable at one's place of work) (pp. 32-34).

necessities for people to be able "to pursue a dignified and minimally flourishing life" in any societal and/or political environment (ibid., pp. 32-33). Furthermore, understanding well-being through the dimensions of living well emphasises the importance of meaning, purpose, engagement, relationships and mastery (Youngson, 2012, p. 13; Ascenso, Williamon & Perkins, 2016, p. 66).

This research focuses on healthcare professionals' experiences of well-being in the social framework of participatory music-making in their workplace. Thus, with the basic premise of well-being as a person's capabilities to flourish and sustain *good life*, it is relevant to examine more deeply theories of social, emotional, psychological and musical factors, which contribute to well-being in the occupational context of healthcare.

3.3.2. Flourishing: a central concept of good life

Drawing upon the field of Positive Psychology[58], the elements and predictors of *good life* are considered as critical components that contribute to human *flourishing* (Seligman, 2011, Compton & Hoffman, 2013; Ascenso et al., 2016). Flourishing is considered as the optimal[59] state of emotional, psychological and social well-being (Keys & Lopez, 2002; Seligman, 2011). The originator of the discipline of positive psychology, Seligman (2011) theorises that good life as *flourishing* is constructed by elements of positive emotions: engagement, relationships, meaning, and accomplishments, which constitute the foundation of the PERMA model of well-being.

In the PERMA model (Seligman, 2011), *Positive emotions* refer to the feelings of pleasure, satisfaction and comfort that underline 'pleasant life' (p. 11); *Engagement* refers to the joy of being absorbed in an activity with concentrated attention (p. 16); *Relationships* refer to the joy of sharing kindness with other people rather than prioritising solitude and disconnection from the others (p. 20); *Meaning* reflects a sense of purpose in life, which is facilitated through feelings of belonging, as well as serving something that is greater than oneself (p. 17); and *Accomplishment* refers to "achieving life" or the pursuit of accomplishment, mastery or victory for its own sake (p. 19). Seligman (2011) highlights that the PERMA model is a construct of elements which contribute to well-being rather than a static state of being (p.

58 Positive psychology is the study of "positive human functioning and flourishing on multiple levels that include the biological, personal, relational, institutional, cultural, and global dimensions of life" (Compton & Hoffman, 2013, p. 2). Positive psychology became a new discipline of psychology in the turn of the millennium after Martin Seligman, the then-president of the American Psychological Association, set out to create a new orientation of psychology focusing on psychological well-being, areas of human strength and positive, adaptive, creative and emotionally fulfilling aspects of human behavior (ibid.).

59 Keys and Lopez (2002) recognise four states of mental health; *flourishing*, *struggling*, *languishing* and *floundering* on the dimensions of well-being and (mental) ill-being. These four types apply across three levels of well-being: emotional, psychological and social well-being. The emotional component of flourishing is defined as emotional vitality and subjective satisfaction with life, psychological well-being is connected to an autonomous and self-accepting life where personal growth and positive relationships with others are possible, and social well-being encompasses five dimensions: social acceptance (holding positive attitudes towards others), social actualisation (believing that society can develop and evolve), social contribution (believing in one's ability to contribute to society), social coherence (the degree to which an individual can make sense of society), and social integration (the degree to which a person feels a part of his/her community) (Keys, 1998). A person who is flourishing has a high state of emotional, psychological and social well-being and low occurrence of (mental) ill-being (Keys & Lopez 2002; Compton & Hoffman, 2013).

15). Each of the five elements of PERMA have the following three properties: they contribute to well-being, they are pursued for their own sake, and they are defined independently from the other elements (Seligman, 2011, p. 16).

The PERMA model recognises both hedonic (i.e., pleasure and satisfaction as the basic component of the good life) and eudaimonic (i.e., the pursuit of fulfilling of one's potential and finding meaning and purpose as the basic component of the good life) dimensions of well-being (Seligman, 2011; Compton & Hoffman, 2013, pp. 43-46; Ascenso et al., 2016, p. 67). The basic premise of Positive Psychology on well-being is that people are "drawn by the future, not driven by the past" (Seligman, 2011, p. 104). In line with Dell'Oro (2006) and Nussbaum (2011), this view entails a capability to adapt to and flourish despite changing circumstances. The notion of human future-orientedness is in line with the pragmatic positioning of this research (see Dewey, 1938/2015 in section 3.1.1).

A central focus of Positive Psychology is the relationship between positive emotions and well-being, because emotions[60] and moods can impact "nearly any psychological process e.g. attention, memory, experience of self" (Compton & Hoffman, 2013, p. 33). Furthermore, flourishing encompasses "the interconnections between people and their environments" (DeNora & Ansdell, 2014, pp. 5-6) as it happens situationally through reciprocal connectivity within a social and cultural landscape (Ansdell & DeNora, 2012). Ansdell & DeNora (2012) sum: "well-being involves our flourishing together" (p. 110).

The positive emotional connections between flourishing people are based on altruistic motivation (Bunkers, 2010; Compton & Hoffman, 2013). In the healthcare profession, especially, the essence of the care lies on the healthcare professionals' altruism[61], which can optimally be cultivated into compassionate acts of care towards patients or residents (Ricard, 2013). According to Ricard (ibid.), altruism can be seen as an urgent necessity in the contemporary world, as it is "the consideration for the well-being of others, their quality of life, and promoting caring, reciprocity, and respect of others" (p. 10).

3.3.3. Flourishing at work: occupational well-being and positive emotionality

In the framework of flourishing, occupational well-being encompasses a person's "productivity and job satisfaction, relationship stability, physical health and longevity" (Ascenso et al., 2016, p. 66). Flourishing at work increases one's intentions to stay in the profession, improves work performance and professional behaviour (Redelinghuys &

60 Compton & Hoffman (2013) define emotions as "focused feelings that can appear or disappear rapidly in response to events in the environment" (p. 33). Emotions differ from moods that usually maintain their tone and last longer (ibid.).

61 Research centres of compassion and altruism studies of Stanford University: the Center for Compassion and Altruism Research and Education, CCARE (see Stanford University, n.d.) and the University of Arizona: the Center of Compassion Studies (see University of Arizona, n.d.) draw upon the Buddhist philosophy that recognises four limitless contemplations as the different faces of altruism. Gilbert & Choden (2013) list them as:

1) Loving-kindness (*maitri*) – the wish for all beings to have happiness and causes of happiness
2) Compassion (*karuna*) – the wish for all beings to be free from suffering and causes of suffering
3) Sympathetic joy (*mudita*) – rejoicing for the well-being and happiness of others and appreciating the positive things in life
4) Equanimity (*upekkha*) – a calm and even-minded state of being in which individuals remain composed when faced with challenges and continue to treat others with warmth and kindness despite the circumstances.

Rothmann, 2018, p. 5). A positive work environment plays a role in the flourishing of employees in the workplace (ibid., p. 6). Especially in the nursing profession, positive experiences of emotional and practical support, as well as feelings of being accepted as a member of the work team, are crucial factors of well-being for novice nurses, in particular (Ten Hoeve, 2018, p. 97).

Positive emotionality at work is linked to increased job satisfaction, energy and excitement about one's occupation, as well as displays of altruism, helpfulness and generosity, enhanced creativity and social relationships (Compton & Hoffman, 2013; Ascenso et al. 2016, p. 67). These factors contribute to decreasing emotional exhaustion and burnout in the workforce (Compton & Hoffman, 2013, p. 260) and help shorten the after-effects of stress reactions (see also Fredrickson, 1998, 2001). These findings are relevant in the high-pressure healthcare work context (see also Youngson, 2012; Lases, 2017).

Employees with more positive emotionality tend to be more engaged in their work and make greater contributions to their workplace's effectiveness (Peterson, Park, Hall and Seligman, 2009; Compton & Hoffman, 2013, p. 260). Work engagement is the optimal work-related state of well-being which is characterised by "a motivational state of positive well-being involving high levels of energy, enthusiasm, and dedication to one's work" (Lases, 2017, p. 101). When it comes to positive emotionality at work, there are two facets of altruism that seem particularly relevant for this research on the well-being of healthcare professionals. These are compassion and sympathetic joy.

3.3.3.1. Compassion: acts of kindness in the care delivery

When altruistic loving-kindness confronts the suffering of others, it can take the form of compassion. Compassion is not only a wish for all beings to be free from suffering, but it entails *an action* to relieve the suffering of others (Ricard, 2013, p. 26). Compassion is, thus, defined as:

> "the altruistic motivation to intervene in favour of someone who is suffering or is in need. […] Compassion, then, implies a warm, sincere feeling of concern, but does not require that one feel the other's suffering, as is the case for empathy" (Ricard, 2013, p. 53).

Compassion should, indeed, not be confused with empathy, which is the heightened awareness or ability to enter into a resonance with someone else's feelings (Gilbert & Choden, 2013; Ricard, 2013). Ricard (2013) explains that empathy alerts a person to the nature and intensity of another's suffering and so, it "catalyses the transformation of altruistic love into compassion" (p. 26). However, empathy is effortful and "depends on the abilities to imagine being the other, to *walk in their shoes*" (Gilbert & Choden, 2013, p. 110).

Furthermore, compassion is unlike pity, which is "an egocentric, often condescending feeling" with no altruistic motivation (Ricard, 2013, p. 51). Gilbert & Choden (2013) explain that compassion is connected to acts of kindness, generosity, and acceptance of others (p. 98). Compassionate care can also be oriented towards one's own experience as self-compassion. It means acts of kindness, comfort and love towards oneself, especially when under pressure of job demands (Youngson, 2012; Neff, 2015). In a study by Scarlet, Altmeyer,

Knier & Harpin (2017), compassion cultivation training[62] (CCT) was found to improve healthcare professionals' job satisfaction, mindfulness and self-compassion (pp. 120-121).

In the healthcare profession, compassion is one core value of the so-called '6 C's'[63] underpinning person-centred care delivery (Cummings & Bennett, 2012). Cummings and Bennett (2012) explain that compassionate care "can also be described as intelligent kindness and is central to how people perceive their care" (p. 13). For healthcare professionals, compassion can be considered as more beneficial than empathy because achieving caring kindness is what is needed in everyday care interactions. Compassionate care does not require mirroring the other person's feelings (Bloom, 2016). Thus, *rational compassion* takes the patients' suffering or well-being into account without exhausting the healthcare professionals emotionally (ibid., pp. 35, 51, 111). In his call for the cultivation of compassionate care, Youngson (2012) refers to the need of small acts of kindness in the everyday care delivery.

3.3.3.2. Sympathetic joy: rejoicing for the other

Studies suggest that altruism leads to profound personal satisfaction (Ricard, 2013, p. 81). The acknowledgement of the value of the others and rejoicing for their happiness is accompanied by a sense of gratitude (ibid., pp. 264-265). Psychologists have found that emotional gratitude is beneficial for well-being as it reinforces prosocial behaviour and emotional ties, and also diminishes envy and negative attitudes (McCullough, Emmons & Tsang, 2002; Ricard, 2013). The benefits of rejoicing for others are connected to the concept of *sympathetic joy* (Salzberg, 2008).

According to the Buddhist teaching, sympathetic joy means perceiving the happiness and good qualities of others without personal interest (Ricard, 2013, p. 27, see also McCormick, 2003). Salzberg (2008) writes that sympathetic joy is "a practice of generosity, and giving isn't just about doing someone a favour – it makes us feel better" (p. 30). Ricard (2013) explains that sympathetic joy manifests as the appreciation for and celebration of the flourishing of others (p. 27). As such, sympathetic joy or rejoicing for the happiness of others is an important concern and value in the nursing practice (Jormsri, P., Kunaviktikul, W., Ketefian, S., & Chaowalit, A., 2005). Jormsri et al. (2005) explain that it "includes feeling appreciative pleasure (affective dimension) when seeing others happy and when seeing others do good actions or attain success and advancement" (p. 588). According to Jormsri et al. (2005), sympathetic joy also means "responding gladly (cognitive dimension) by providing help and supporting others as they struggle to do good (behavioural dimension)" (p. 588). Sympathetic joy in the nursing profession promotes relationships between nurses and patients (ibid.). Jormsri et al. (2005) write:

> "With respect to sympathetic joy, nurses express pleasure when seeing patients happy, and when they succeed in obtaining medical care or regain their health. Nurses co-operate with nursing team members and other healthcare providers by providing

62 Compassion cultivation training (CCT) has been developed by Stanford University School of Medicine and consists of eight 2-hour weekly group sessions (Scarlet et al., 2017, p. 119).

63 The so-called '6 C''s underpinning the values of healthcare delivery are *care*, *compassion*, *competence*, *communication*, *courage* and *commitment* (Cummings & Bennett, 2012, p. 13).

sincere help and support, and they feel happy when seeing others carrying out good actions or attaining success and advancement" (p. 588).

Sympathetic joy has not been sufficiently studied in scientific literature. For example, Royzman and Rozin (2006) point out that there is an apparent lack of study in sympathetic joy, or *symhedonia*, even though "it would seem like a pressing topic for those with an interest in other-regarding affect in general and altruism (benevolently other-regarding) emotions in particular" (p. 82).

3.3.3.3. Mindful presence: resources for occupational well-being and care delivery

In line with Seligman's (2011) concept of engagement, focused attention in the present experience as an element of flourishing (see section 3.3.2) and mindfulness practice has also been found to impact occupational well-being. Mindfulness means "paying attention to one's own ongoing experience in a way that allows openness and flexibility" (Compton & Hoffman, 2013, p. 90). Mindfulness aims towards full *presence* of an activity while it is being performed, and to become open and aware of one's own life experiences and outcomes of one's activities (ibid.).

Mindfulness links to the Greek concept of *Kairos*. Unlike the linear passing of time, Chronos, Kairos as the second dimension of time describes the quality of the moment at hand (Lombarts, 2010; Hermsen, 2015). Kairotic time (also known as 'kairological' time, see Loney, 2018, p. 116) is a subjective experience, where a person identifies and feels a 'right moment' as it unfolds (Loney, 2018, p. 116.). Kairos is a passing instance that, often unexpectedly, bares the meaning and value of the moment (see Rusi-Pyykönen, 2020, pp. 73, 184). It is, however, more than a *temporal reference*. It also carries spatial meaning: the right scope of things at hand (Sipiora, 2002, p. 2). Kermode (1966/2000) writes that Kairos is "that point in time filled with significance, derived from its relation to the end" (p. 47). Here, Kermode means that the kairotic moment is established in relation to its past, present and future (ibid., p. 50). This last notion aligns with Dewey's (1938/2015) pragmatic concept of experiencing as a continuum underpinning growth and living (see section 3.1.5).

The concept of Kairos has been connected to later notions of concord between people interacting with each other (see Sipiora, 2002, p. 5). Rusi-Pyykönen (2020) points out that kairotic processes require *presence* and flexible, reflexive thinking-in-action of the people involved in the moment at hand (p. 186). In the context of participatory arts, the kairotic interplay between participants can be ignited in the present moment by, e.g. improvisation, which can give new meaning to the evolving social situation (ibid., p. 187).

Through 'kairotic' moments of mindful presence, circumstances and opportunities of flourishing can be created (Compton & Hoffman, 2013). In the context of healthcare, for example, engaging with one's patient with full attention during passing moments has been found to be beneficial for nurses' job satisfaction and flourishing at work (Youngson, 2012), because a significant part of striving to flourish in the care profession is connecting with others *in the moment* (Lases, 2017). It requires genuine presence (Bunkers, 2010). Youngson (2012) writes that when one is fully present, "connection with others is dramatically enhanced. Time stops […]. This is the state in which compassion and loving kindness occur" (p. 60).

Mindfulness is a key concept of compassion cultivation in healthcare, as it is a practice of focused and attentive participation in the ongoing life experiences, instead of habitual doing (Langer, 1989; Youngson, 2012, p. 64). Mindfulness can be considered as a link to the pragmatic concept of *experimental responsiveness* that is distinct from habitual actions (see Elkjaer, 2009, pp. 77-78 in section 3.1.3), as well as Turino's (2008) notion of gaining a "temporary sense of a life more deeply lived" through musical engagement in the present moment (p. 18, see section 3.1.6).

In line with Turino's (2008) notion of being *awakened from habit* by musical imagining (see section 3.1.6), Langer (1989) explains that mindfulness fosters creativity and new awareness of an experience, as well as a new perspective beyond what one's point-of-view allows her/him to see. Hence, mindfulness helps to break down rigid thoughts and judgements on one's experience and increase sensitivity to the context of the experience (ibid.). In the healthcare context, mindfulness practice can, thus, facilitate well-being by helping a person become aware of the risk factors of burnout in her/his work (Langer, 1989) and become *better attuned* to the needs of the patients or residents and oneself (Youngson, 2012, pp. 65, 68).

As explained in section 1.2, person-centred care is embedded in *presence* (Youngson, 2012; Ross, Tod and Clark, 2014). Main characteristics of '*presence practice*' [64] or '*presence care*' are loving devotion, subtilty, practical knowledge and craftmanship, as well as courage in terms of initiating interaction and taking responsibility (Van Heijst, 2005; Baart in Adriaansen et al., 2008). The core of presence in the healthcare profession lies in the ability to relate to 'the other' with attention, dedication and emotional availability (Baart, 2001). Van Heijst (2005) explains that in presence practice, the healthcare professionals' presence is aimed to assist people who are locked in themselves, their condition or the situation at hand.

In brief, presence practice or *presencing* (see Benner, 1984/2001, p. 57) does not have much to do with *doing* something for the other, but more with *being* for the other, although one does not exclude the other (ibid., p. 57). Through presence, *fellow humanity* can be found between the healthcare professional and the person receiving care (Van Heijst, 2005; Benner, 1984/2001). Although presence practice begins with an unequal situation of urgent need, the care relationship has a potential to grow reciprocally (Van Heijst, 2005). Subsequently, the patient or resident can become a 'fellow human' to the presence practitioner by inviting her/him to emerge as a person rather than a care figure (ibid.). The asymmetry of the beginning of the care relationship can, thus, begin to shift towards a mutual acknowledgement of each other's dignity and human qualities.

Presence practice, in line with the values of person-centred care (see Kitwood, 1997 in section 1.2) and the theory of flourishing (see Seligman, 2011 in section 3.3.2), aims to open up positive aspects of life by focusing on the person's capabilities beyond their condition

64 The concept of 'presence practice' is based on Baart's (2001) "Theory of Presence" in healthcare. The Theory of Presence calls for healthcare professionals' appropriate responses to people in care and an ability to adjust themselves to the patients by being open and receptive to them (Kuis, Knoope & Goossensen, 2014, p. 24). In line with treatment-focused intervention care, presence practice, too, is focused on relieving the suffering of others, but it does not claim that all suffering can be relieved quickly or effectively through treatment interventions (Van Heijst, 2005). Baart's (2001) Theory of Presence provides a suggestion for transforming professional care relationships between strangers into fellow human-loving relationships (Van Heijst, 2005, p. 261). Such transformation promotes a relationship-oriented or person-centred care culture instead of a task-centred culture of care.

(ibid.). Where intervention care is appropriate for aiming to relieve singular sufferings, presence care is appropriate for approaching the relieving of multiple sufferings, even the ones that are untreatable (ibid.) Even if the approaches (intervention and presence care) complement each other, the presence care ideology provides a reorientation of the horizon of healthcare (Van Heijst, 2005; Youngson, 2012).

3.3.3.4. Limitations of flourishing in healthcare: detachment and empathic exhaustion

It has been argued that mindful presence practice is a cornerstone of relationship-oriented, person-centred care that supports healthcare professionals' occupational flourishing. Professional distance, however, is a limiting factor for presence care as it means detaching oneself from engaging emotionally with the patients or limiting contact with them during care delivery (Youngson, 2012). In the working culture of healthcare, professional distance stems from the need for self-protection against intense emotions (Pool, Mostert & Schumacher, 2005), as well as ideals of professional effectivity in the Western healthcare framework (Van Heijst, 2005; Youngson, 2012).

Becoming emotionally distressed by witnessing patients' suffering (see Scarlet et al., 2017, p. 117) can lead to emotional fatigue (Ricard, 2013, p. 40). *Emotional fatigue*[65] increases the risk of burnout, especially in professions where people are confronted regularly with others' sufferings, such as in the fields of healthcare and social work (Ricard, 2013; Scarlet et al., 2017, p. 117). Emotional fatigue is set off by empathy, which causes actual suffering[66] (Bloom, 2016). The problem with empathy in healthcare is that "patients come and go, but the burden of empathic suffering of the medical staff is renewed day after day" (Ricard, 2013, p. 323). Emotional exhaustion may prevent the fatigued healthcare professionals from forming human relationships with patients as burnout inhibits them from giving affectionate care with presence and contact (Ricard, 2013, p. 337). Therefore, emotional exhaustion is a crucial issue in the care profession as it impacts both the healthcare professional and their care community, as well as the patient.

Subsequently, the circumstances of the care environment can inhibit healthcare professionals' authentic interactions with their patients, which can create an emotionally unresponsive or aversive workforce (Van Heijst, 2005, p. 199). Ten Hoeve (2018) explains that nurses who are emotionally committed to their work, experience higher job satisfaction and less work-related stress than those who are detached emotionally from their work (p. 143). Yet, the profession requires coping with "high emotional demands" (ibid., p. 143). Benner (1984/2001) argues that nurses who are involved with their patients by *being there* find it easier to draw upon their resources to cope with the demands without the need for distancing themselves (p. 164). Benner (1984/2001) states:

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65 The symptoms of emotional exhaustion are feeling worn-out, cynicism and increased insensitivity to towards others. Also, when burned out, a person often loses a feeling of personal accomplishment and develops feelings of failure (Ricard, 2013, p. 326). Ricard (2013) explains that the feeling of being powerless to create change due to unfavourable circumstances at work can lead to intense feelings of suffering (p. 327).

66 Ricard (2013) and Bloom (2016) explain that studies in neuroscience (i.e Singer & Lamm, 2009; Singer & Klimecki, 2014) have shown that during empathic resonance to suffering of others, neural networks which process pain or distress activate similarly to when one experiences suffering personally.

> "I suspect that distancing techniques dimly protect the nurses from the pain in the situation, but they also prevent them from taking advantage of the resources and possibilities that come through engagement and participation in the patients' and families' meanings and ways of coping" (p. 164).

3.3.3.5. Job Demands and Resources: a model of occupational thriving

The Job Demands – Resources (JD-R) theory by Bakker & Demerouti's (2014) explains how job resources and demands have unique effects on a person's experiences of occupational stress and motivation (p. 2). It is one of the most prominent contemporary theoretical approaches to model occupational psychology and well-being (Schaufeli & Taris, 2013), likely because of its applicability and flexibility in various working contexts and occupational profiles (Bakker & Demerouti, 2014). The JD-R model has been widely used to predict job satisfaction, work engagement and burnout in various professional fields (ibid.).

According to the JD-R theory, all work environments can be modelled by two variables, *job demands* and *job resources*. Job demands are physical, psychological, social or organisational aspects of one's work (e.g. high work pressure) that require effort and can increase stress (Bakker & Demerouti, 2014). They may not be experienced negatively, however they "may turn into hindrance demands when meeting those demands requires high effort from which the employee has not adequately recovered" (ibid., p. 9). Job resources, on the other hand, refer to the physical, psychological, social or organisational aspects that are needed to achieve work goals, reduce job demands, and stimulate personal growth, learning and development (Demerouti & Bakker, 2011, p. 2).

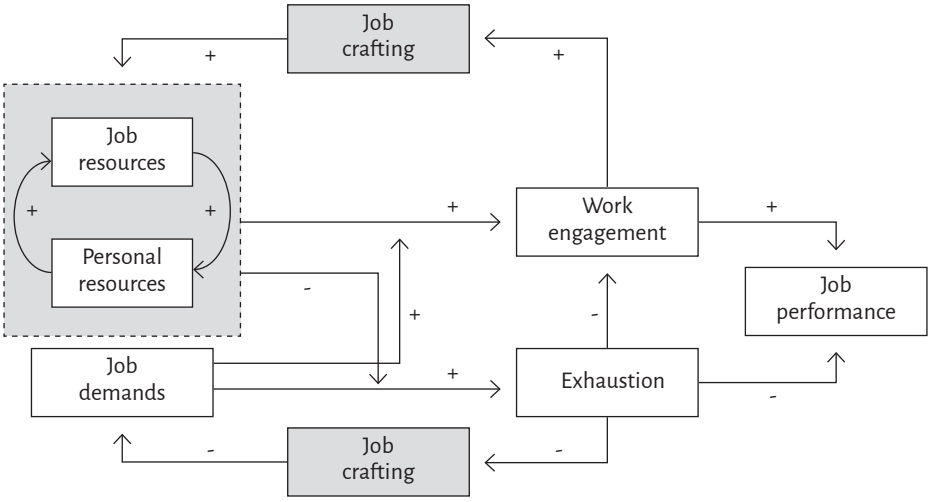
Supporting job resources helps employees to cope better with the everyday work but they are also important in their own rights (Bakker & Demerouti, 2014, pp. 9,11). Bakker & Demerouti (2014) explain: "Whereas job demands are generally the most important predictors of such outcomes as exhaustion […] job resources are generally the most important predictors of work enjoyment, motivation, and engagement" (p. 9).

The JD-R theory suggests that there are two kinds of occupational resources that support work engagement and performance: job resources and personal resources (Xanthopoulou, Bakker, Demerouti & Schaufeli, 2007). The focus on and inclusion of personal resources are an important extension to the original JD-R model (Bakker & Demerouti, 2014). According to Bakker & Demerouti (2014), personal resources refer to resilience and positive self-convictions that support a person's sense of control and self-efficacy in the workplace, which are connected to enhanced motivation, job satisfaction and increased work performance (ibid., pp. 12-13).

Finally, the JD-R model suggests that working life can be shaped by *job crafting* (Bakker & Demerouti, 2014). Job crafting[67] refers to employees' ability to "actively change the design of their jobs by choosing tasks, negotiating different job content, and assigning meaning to their tasks or jobs" (ibid., p. 15). See Figure 1 visualising the JD-R model (after Bakker & Demerouti, 2014, p. 10; Bakker & Costa, 2014, p. 2):

67 Tims, Bakker & Derks (2012) found that there are four typical forms of job crafting: increasing structural job resources, increasing social job resources, increasing challenging job demands, and decreasing hindrance job demands.

Figure 1. The Job Demands – Resources model (JD-R) after Bakker & Demerouti (2014).



The plus and minus signs in Bakker & Demerouti's (2104) visualisation of the JD-R model above indicate the *decreasing* and *increasing* effects that job demands, job resources and job crafting can have on work engagement, exhaustion and ultimately, job performance. Notably, the model implies that job demands, too, can feed positively into work engagement if the 'friction' they create is constructive and enhances fulfilment by bringing about positive challenges into the work (ibid.).

3.3.4. Music-making as a component of well-being

3.3.4.1. Positive emotionality in musical engagement

Various studies suggest that engagement with music is strong catalyst for evoking positive emotionality, mood and a sense of well-being and good life (Hays & Minichiello, 2005; Creech, Hallam, Varvarigou & McQueen, 2014). In neurocognitive terms, familiar music, as well as *novel musical stimuli* such as listening to improvised music that is "heard for the first time, without any therapeutic goals, can elicit strongly positive feelings and limbic activation" (Bernatzky, Presch, Anderson, & Panksepp, 2011, p. 1995).

When it comes to the social aspects of emotionality and musical engagement, Turino (2008), Finnegan (2012) and Hesmondhalgh (2013) argue that the function of music as a resource for emotional arousal has significant social value for connecting people in social communities. Studies have found a link between meaningful relationships within *social networks* of music-making and social-emotional well-being (Creech et al., 2014, p. 16). Musical engagement can be considered as a significant social-emotional resource, especially in ageing societies, as the enhancement of well-being through music-making is connected to positive emotionality, pleasure, fellowship, friendliness and warmth (ibid., pp.

18-27). Music can also increase motivation to social participation, offer a distraction from medical conditions and provide means for meaning-making of one's own and the others' experiences (Hays & Minichiello, 2005).

3.3.4.2. Flourishing through musical experiences

Music-making is connected to improving well-being in multiple contexts. Ascenso et al. (2017) state that music can work as a *well-being enhancer* in "everyday use, community, clinical and education" (p. 66). DeNora & Ansdell (2014) explain that musical engagement and experiences can accumulate *moments of flourishing* or add to one's *capacity to flourish* (p. 9). What is notable about flourishing through music is that "it is not the music per se that accomplishes this enhancement but rather what is done with, done to, and done alongside musical engagement" (DeNora & Ansdell, 2014, p. 9). Therefore, music has potential for promoting flourishing *in action* (Hesmondhalgh, 2013; DeNora & Ansdell, 2014). In line with Creech et al., (2014), Ruud (2012) agrees that the *healthfulness* of live music is rooted in active engagement with music in the social situation (p. 88). Engagement in or with music can, furthermore, induce states of mindfulness and contribute to creating relaxation, positive emotionality and awareness in the moment (Lecuona and Rodriquez-Carvajal, 2014, p. 6).

When it comes to healthcare professionals' flourishing through artistic engagement at their workplace, it has been suggested that artistic interventions can be a "source of well-being as well as an enrichment to the work environment" (Halonen & Strandman, 2012, p. 47). Furthermore, artistic practices can offer a new perspective and methods to solving various care-related challenges (Halonen & Strandman, 2012). Musical engagement is reported to be a powerful force of enhancing healthcare professional's creative agency and work engagement (Huhtinen-Hildén, Puustelli-Pitkänen, Strandman & Ala-Nikkola, 2017).

3.3.4.3. Live music as a resource for well-being in hospital care

Although there is no shortage of studies into the impact of music on health and well-being, research on live music is relatively understudied compared to research that has been done on recorded music listening[68] (Moss et al., 2007; Van der Wal-Huisman, Dons, Smilde, Heineman and Van Leeuwen, 2018, p. 4). Van der Wal-Huisman et al. (2018) state that "live music can adapt to the patients' situation[s] in a way that recorded music cannot" (p. 556). For example, live music can help both patients and nurses to feel more satisfied by balancing the aural environment of medical sounds and creating enjoyable social interactions that may transform the hospital experience (Wolf & Wolf, 2011; Petrucci, 2018; Hawley, 2018). Hawley (2018) describes that during live music sessions in a hospital, "[medical] professionals and families engage with live music and musicians, as a natural part of hospital life" (p. 7).

68 The outcomes of the research on recorded music listening are positive in many areas: positive physiological and psychological changes in hospitalised patients, including decreasing perception of pain, anxiety and/or stress (Evans, 2002; Nilsson, 2008; Bernatzky, G., Presch, M., Anderson, M. & Panksepp, J. 2011; Bernatzky, G., Strickner, S., Presch, M., Wendtner, F., Kullich, W., 2012; Van der Wal-Huisman et al., 2018), reduction of drug consumption, lowering heart and respiratory rates (Gélinas, Arbour, Michaud, Robar & Côté, 2012), distraction from the hospital realities, shortening the length of the hospital stay, and promoting an enhanced doctor-patient relationship (Staricoff & Clift, 2011).

Furthermore, Hawley (2018) explains that through the music-making, a "sense of time and space expand and contract in moments of music creation" (p. 7).

Substantial research has shown numerous health benefits associated with music as a strategy for reducing the stress of nursing staff, improving mood and increasing empathy towards patients (Bittman et al., 2003; Bittman, Snyder, Bruhn, Liebfreid, Stevens, Westengard & Umbach, 2004; Happell et al., 2013; Repar & Reid, 2014). According to Wolf & Wolf (2011), music interventions are an effective tool to motivate, inspire and develop nurses professionally by engaging them in projects that promote positive social change in the work environment. Participatory live music sessions in hospitals can help healthcare professionals become closer to patients through musical interaction and the creative, emotional outlet that it provides, as well as allow new partnerships to be formed between the healthcare professionals and musicians (Daykin, 2012). Similarly, Petrucci (2018) proposes that live music can help nurses to build deeper relationships with patients (p. 1). Furthermore, interactive music sessions can improve elderly patients' cognitive understanding of the care being provided to them, and therefore help the processes of caregiving (Götell, Brown & Ekman, 2000; Daykin, Parry, Ball, Walters, Henry, Platten and Hayden, 2017).

Finally, O'Callaghan & Magill (2008) state that music can support hospital care because it can have a stress-reducing effect on nurses and improve the work environment by creating a sense of peace, comfort and liveliness. In regard to liveliness, a study on oncology nurses' perceptions of music at their workplace revealed that live music was preferred over recorded music because it allowed the nurses to interact with the musicians (see Lai, Li & Lee, 2011).

3.3.4.4. Live music as a resource for well-being in nursing home care

Participatory music practices for elderly people with dementia can nurture cognitive, physical[69] and social well-being by building relationships that can make the person behind the dementia visible again (Garrett, 2009; Power, 2010; Habron, Butterly, Gordon and Roebuck, 2013, p. 309; Smilde et al., 2014). Even in the final stages of all types of dementia, music can have a positive influence on the elderly person's well-being (Smilde et al., 2014). So, music practices in nursing home care can contribute to an elderly person's acquired outlet of expression, increased social engagement, reinforced mental strength and confidence (Gould, 2012; Ruud, 2012; Foster, 2014). Habron et al. (2013) as well as Roe (2013) add that participatory music sessions can strengthen a feeling of self-esteem, meaningful occupation, and a sense of control. These aspects can be seen as *positive ageing* through music (Creech, 2018, p. 102).

When it comes to strategies for coping with the symptoms of dementia in nursing home care, studies suggest that the use of music can help caregivers reinforce their relationships with residents and, subsequently, reduce the caregivers' stress and professional fatigue (Bouhairie, Kemper, Martin & Woods, 2006; Brooks, Bradt, Eyre, Hunt & Dileo, 2010). Music can also be integrated into residents' individual care plans in nursing homes. For example,

69 Koyama, Wachi, Utsuyama, Bittman, Hirokawa & Kitagawa (2009) found that music-making has a potential of increasing nursing home residents' social and personal satisfaction but also, improving their immunological stress responses. Pharmaceutical solutions rarely result in similar hybrid outcomes of health promotion (see also Nair, Browne, Marley & Heim, 2013).

Götell, Brown and Ekman (2002) studied nursing home caregivers who began singing to their residents while performing various care routines. As a result, the residents' acceptance of care increased (ibid).

Although caregivers appear to have a mostly positive attitude towards the use of music with people with dementia, they are unlikely to employ music in the care delivery (Sung, Lee, Chang and Smith, 2011). This unlikeliness may be connected to the caregivers' experienced lack of time and perceived lack of musical skills (ibid.).

4. A QUALITATIVE ETHNOGRAPHICALLY INFORMED RESEARCH DESIGN

4.1. Qualitative positioning in empirically grounded theory and abductive reasoning

4.1.1. An abductive qualitative research approach

This research is a qualitative study that aims to understand and explain social phenomena arising from the interpreted experiences of healthcare professionals in participatory live music practices in their workplace. Qualitative research belongs to the interpretative paradigm of research. Qualitative research is interested in discovering and capturing aspects of social life (Flick, Von Kardorff & Steinke, 2004; Krüger, 2008; Saldana, 2011) and generate new knowledge of individuals' "shared understandings and negotiation within a historical and social context" (Krüger, 2008, p. 13). Qualitative research is an umbrella term for a variety of methodological approaches and concepts (Saldana, 2011, p. 3; Flick, 2014, p. 17).

In qualitative research, the researcher develops understandings of social life in specific settings through her/his own interpretative lens (Krüger, 2008; Flick, 2014). In an *abductive approach* to qualitative research, the researcher addresses her/his outspoken pre-assumptions of the research topic and creates a dialogue between the empirical data and the theoretical bodies of knowledge throughout the research process (Eskola & Suonranta, 1999; McKaughan, 2008). Therefore, the researcher's preconceptions do not pre-empt the conclusions of the study (McKaughan, 2008). By considering all possible explanations for the data and forming multiple possible explanations throughout the research process (Charmaz, 2006; Robson & McCartan, 2016), the researcher eventually arrives at "the most plausible interpretation of the observed data" (Charmaz, 2006, p. 186; see also Saldana, 2011, p. 93).

4.1.2. Grounded theory: from empirical hunches to a thick description

Abductive reasoning is a cornerstone of knowledge generation in qualitative, empirically grounded theory research (Charmaz, 2006). Grounded theory[70] is an approach to carrying out qualitative research in a way which focuses on creating conceptual frameworks or theories that are rooted in empirical data (Charmaz, 2006, p. 187). Therefore, the researcher

70 Grounded theory was first developed by sociologists Glaser and Strauss (1967), who proposed it as a systematic qualitative research approach that could generate legitimate and substantial middle-range theories grounded in data (Charmaz, 2006; Smilde et al., 2014). After the development of Glaser and Strauss' *classical* grounded theory, the pioneering theorists continued to develop the theory further in two separate lines: Glaser's *traditional* (objectivist) grounded theory and Strauss and Corbin's *evolved* grounded theory, which had differing views on the use of literature and the researcher's presence in the research process (Ramalho, Adams, Huggard & Hoare, 2015). Eventually, following Strauss and Corbin's evolved grounded theory that recognised the researchers' experiences and the use of literature throughout the research process, a third main approach to grounded theory was introduced by Charmaz (2000; 2008). It is known as the *constructivist* grounded theory approach (Charmaz, 2008).

operates without fixed pre-formulated hypotheses and the grounded theory research process can lead cumulatively to a gradual formation of theory as the research and analysis progress (Charmaz, 2006; Saldana, 2011).

In this research, I employ a *constructivist* approach to grounded theory. The constructivist grounded theory approach understands the research data and concepts to stem from the researcher's interactions within the field of study (Alvesson & Sköldberg, 2018, p. 96). The researcher's presence in the process of theory formation is therefore neither neutral nor undesirable (Ramalho, Adams, Huggard & Hoare, 2015). Instead of expecting the researcher to stand separately from the research participants and their social realities, constructivist grounded theory "*depends* on the researcher's view; it does not and cannot stand outside of it" (Charmaz, 2006., p. 130). Because constructivist grounded theory considers theory formation as a socially constructed process, it has evolved to take a *relativist pragmatist* positioning on epistemology and ontology, meaning that it has abandoned an idea of any kind of a pre-existing reality (Mills, Bonner & Francis, 2006). Instead, constructivist grounded theory emphasizes the quality and depth of the interpretations of social phenomena (Charmaz, 2006; 2008).

The grounded theory process employs underlying research mechanisms of coding, memo-writing, sampling for theory development and constant comparison of the data (Saldana, 2009). In the grounded theory research process, empirical data is gathered, immediately analysed and re-constructed by coding (Ramalho et al., 2015). In the process of the analysis, the researcher develops new code categories that originate and evolve from the raw data (Mills et al., 2006; Krüger, 2008; Untamala, 2014). The core categories (clusters of concepts) will finally lead to the description of a theory that is applicable to practice. I chose the grounded theory approach for this research particularly because my aim was to build a middle-range theory[71] that would be applicable for the professional practice of musicians and nurses.

Grounded theory allows the researcher to produce *a thick description* (see Geertz, 1973): an in-depth interpretation of the studied social situations through combined extensive fieldnotes of observations, transcriptions of participants' accounts and other detailed narratives (Charmaz, 2006; Bhattacharya, 2008). Grounded theory analysis should be written conceptually rather than descriptively (Untamala, 20014, p. 134). In other words, the research aims to translate the participants' expressed experiences "into readable theoretical interpretations" (Mills et al., 2006, p. 32). The thick descriptions, as such, provide in-depth understanding of *what is going on* in the research participants' terms (Robson & McCartan, 2016, p. 157).

4.1.3. Sensitising concepts: from the first assumptions to questions to ask

In the very beginning of the grounded theory research process, the researcher's first notions about the research topic are known as *sensitising concepts* (Schreiber, 2001). Sensitising concepts are loose background assumptions that provide initial ideas to pursue in the

71 Generating a *middle-range theory* is an approach to sociological theory construction, which is particularly applicable to practice (Roy, 2014). Compared to a broader *grand theory* that does not rely on empirical data, theorising social life through generating a middle-range theory has a focused scope bounded by empirical observations (ibid.). Hence, a middle-range theory integrates theory and empirical research (ibid.).

research and sensitise the researcher to a particular kind of question about the research topic (Charmaz, 2006, p. 16). Sensitising concepts provide a *flexible frame of interest* which can be understood as the point of departure in the research (ibid, pp. 16-17). Sensitising concepts stimulate the researcher to "perceive new relations, perspectives and worldviews" (Alvesson & Sköldberg, 2018, p. 71), and as such, they help to develop initial understandings of the research topic rather than limit them (Van den Hoonaard, 1997; Charmaz, 2006).

In this research, the sensitising concepts arise from a forestudy on Music for Life and Musique et Santé, including a literature review on the two practices in 2015-2016 (see section 2.1), two pre-pilot projects preceding the practice development of the MiMiC practice in late 2015, as well as a broad literature reviews on live music in healthcare. I continued the literature reviews throughout the research process as my sensitizing concepts developed into workable ideas.

During the preparatory period of my research, I wrote down concepts and sentences that seemed relevant for my research focus based on what was captured in interviews, first observations and literature. I formulated my loose ideas through reflections on these materials. The emerging flexible working hypotheses for my research were (a) participation in live music practices in the workplace of healthcare professionals may create new socially shared artistic experiences, and (b) these new experiences may lead to new learning, which could be meaningful for the healthcare professionals' occupational well-being and culture of work. The sensitising concepts developed further throughout the reflective and reflexive processes of the grounded theory research (see sections 4.1.4 and 4.6.1). This led to the formulation of the research questions of my study.

RESEARCH QUESTIONS

The constructivist tradition of grounded theory allows the research questions and problems to be drawn from literature or a personal or professional interest of the researcher before the coding of the data begins (Untamala, 2014). In my research, which is positioned in the field of music education research, the formulation of the research questions aimed to capture healthcare professionals' articulated and observable learning processes in participatory musical situations, as well as the relevance, meaning and benefits of these processes to their occupational well-being and care delivery. The formulation of the research questions was informed by my previous professional practices in elderly care, literature, the expert interviews of the forestudy on the two practices Music for Life and Musique et Santé (see section 2.1), and the two pre-pilots into the MiMiC practice development. All combined, they suggested a relevant angle for my research. Consequently, the research questions underpinning my research became:

1. *What kind of knowing is transferred from interactive music sessions into daily healthcare practices in elderly care and hospital settings?*

2. *What resources and social changes can music sessions generate for nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?*

4.1.4. Reflexivity: the researcher's stance in the qualitative study

Reflexivity is a concept that builds upon the notion that social researchers are co-constructing the social situations which they study (Pollner & Emerson, 2007; Flick, 2014). This concept acknowledges that the researchers' lens through which they observe the world is coloured by their sociohistorical backgrounds, views and experiences (Pollner & Emerson, 2007). Reflexivity is crucial in research because knowledge cannot be separated from the knower (Steedman, 1991). Although reflexivity in qualitative research can be defined in various ways, the basic notion suggests that reflexivity persistently questions the researcher's *ways of doing knowledge* (Alvesson & Sköldberg, 2018, p. 10). Reflexivity can, thus, help the researcher to become aware of and articulate her/his values and judgements on the research process in order to strengthen the validity of the findings and the plausibility of the conclusions. As such, reflexivity is a research stance that encompasses the entire process of the study (see also Alvesson and Sköldberg, 2018).

Instrumentally, reflexivity can help the researcher consider and make sense of the influence of their co-constructive presence in the social situations and processes during data collection (Mruck & Breurer, 2003; Ramalho et al., 2015). In terms of analysis, reflexive memo-writing (see section 4.5.1) is a tool for the researcher to become aware of her/his feelings, questions and growing realisations arising from the data analysis process (ibid.). Reflexive practice in qualitative research is crucial for critically evaluating the reconstruction of one's interpretations (Alvesson & Sköldberg, 2018).

4.2. Ethnographically informed research methodology

The methodology of this research draws upon the tradition of ethnography. Ethnography is one of the oldest forms of social research, and it is driven by the interest of *being there* and getting close to the cultural phenomena one studies (Robson & McCartan, 2016). Ethnography is derived from a tradition of anthropology and seeks to understand and explain both explicit and tacit elements of culture and human action therein (Saldana, 2011; Strandman-Suontausta, 2013). The focus of an ethnographic study is to describe, interpret and understand the nature or the meaning of human action from the point-of-view of a member or members of a particular social context (Strandman-Suontausta, 2013). Ethnography considers people as knowers through their own experiences, meaning that they are seen as active, goal-oriented, knowing and planning agents who make meaning of various aspects of their lifeworld (ibid, p. 55). Therefore, an ethnographic approach keeps an open, descriptive and interpretative research stance (Strandman-Suontausta, 2013; Alvesson & Sköldberg, 2018).

Classical ethnography usually consists of artefacts, participant observation and interviews (Flick, 2014), but in this research, I collected data through participant observation, episodic interviews with narrative passages and group discussions. Furthermore, ethnography explores social processes, events and phenomena as they occur in social situations usually by focusing on a small number of cases (Atkinson & Hammersley, 2007). Similarly, this research focuses on participatory music practices in two healthcare contexts.

In grounded theory research that employs ethnography as a research methodology,

the focus is on a *phenomenon* or a *process* rather than the setting itself (Charmaz, 2006, p. 22), because grounded theory is traditionally orientated towards *change* and interpreting how people respond to it (Corbin & Strauss, 1990, p. 5). These responses can, then, be conceptually rendered into a thick description by the grounded theory ethnographer (Charmaz, 2006, Charmaz & Mitchell, 2007).

In this PhD research, the principles of ethnographic methodology are applied in a research design that combines participant observation, episodic interviews with narrative passages, and group discussions. Hence, I consider the research methodology of this dissertation as ethnographically informed. Although I did not collect artefacts of the studied settings, the participant observation on the MiMiC practice was supported by audio-recordings of the music sessions (see section 4.3.3). The research design and validation of this study build upon *data triangulation* of said three qualitative research methods.

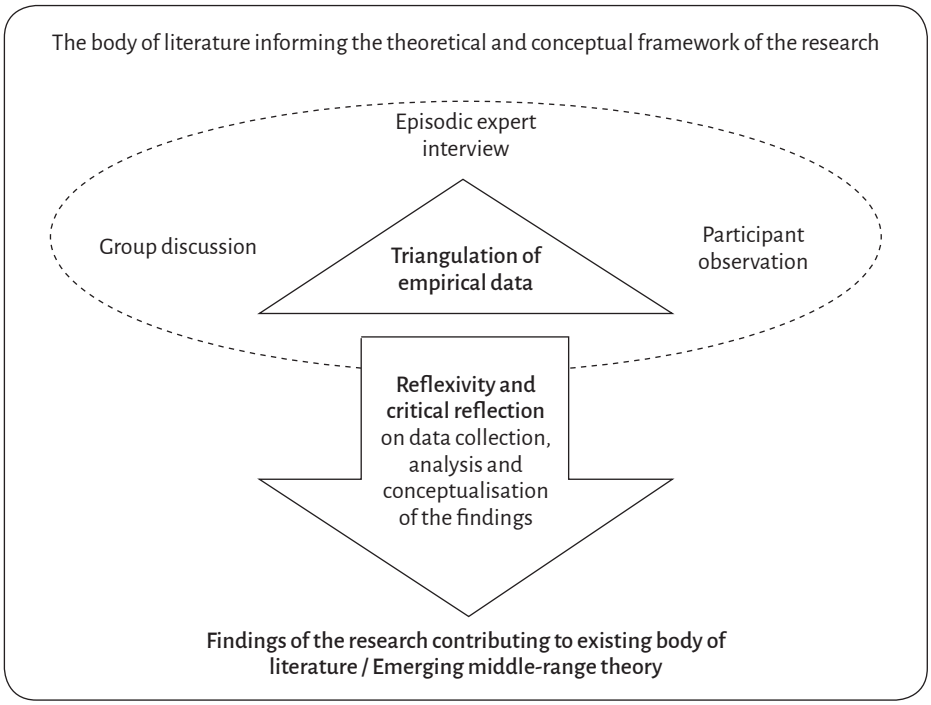
4.3. Validation of the findings: data triangulation underlying the research design

Data triangulation is a procedure and a form of triangulation, where the researcher compares data produced by multiple methods to reinforce the validity of the research findings (Atkinson & Hammersley, 2007; Rock, 2007). As ethnography often involves a combination of research methods, it may be possible to assess the validity of the researcher's interpretations and reconstructed concepts by comparing different data sources relating to the same concept (Atkinson & Hammersley, 2007, p. 184). In other words, data triangulation helps to draw cohesive conclusions from diverse data on the same phenomenon and gives support to the researcher's emerging interpretations (Alvesson & Sköldberg, 2018). Consequently, data triangulation calls for the researcher's reflexivity (see previous section 4.1.4).

The data triangulation (Olsen, 2004) used in this research was intended as a strategy to find a common basis for my interpretations by comparing and combining different types of data with each other. By checking the connections between concepts arising from various sources of data, I aimed to gain as much validation and credibility to my interpretations as possible. So, I triangulated data stemming from participant observation, episodic expert interviews with narrative passages and group discussions (see later sections 4.3.1-4.3.3).

In addition to data triangulation, *member checking* was also used in this research. Davis (2008) explains that like triangulation, member checking, too, can help to increase the validity of the research findings. Member checking means controlling the accuracy of the researcher's interpretations of the data by bringing them back to the research participants for reviewing (Steinke, 2004). Member checking furthermore demonstrates that the researcher values the participants' *perceptions and contributions* (Robson & McCartan, 2016). I validated my data by asking for some participants' feedback on my interpretation of their experiences. In addition, I used the opportunity of *peer debriefing* among the members of the research group Lifelong Learning in Music to ensure the quality of my interpretations of the data.

Figure 2. Data triangulation underlying the design of this research.



4.3.1. Episodic expert interviews with narrative passages

The primary sources of data collection in this research were episodic expert interviews with *narrative*[72] passages as well as group discussions. In line with Strandman-Suontausta (2013), the importance of using interviewing as a primary source of data collection in the healthcare context was evident because it enabled a direct enquiry into the healthcare professionals' experiences of the artistic practices. Using expert interviews was considered as a means of drawing out the participants' expertise for the analysis. The approach used in this research is called *episodic interviews*. It was developed by Uwe Flick (1997), a German scholar of qualitative, social and educational research, whose writings still form the majority of available publications about the method.

Episodic interviewing invites interviewees to recount and narrate experiences of concrete, episodic situations that are relevant for both the interviewee and for the research topic (Flick, 2004; Flick & Röhnsch, 2014). In episodic interviewing, the interviewer is interested in the knowledge that is closely related to experiences and linked to concrete

72 According to Alheit (1993), a narrative approach to interviewing allows the interviewee to tell, relate, recount and recall rather than report or state issues. For an interviewee to narrate freely, the interview situation must be supportive of storytelling: intimate, friendly and unrushed. Therefore, formal situations, such as being at work can make the storytelling difficult. To allow space for the storytelling to happen, it is crucial that the interviewer remains in the background of the interview as much as possible (ibid.).

circumstances (i.e., time, space, persons, events, situations) (Flick, 2014). This kind of knowledge is called *episodic knowledge* (Flick, 1997). Episodic knowledge corresponds with *semantic knowledge*, which is "more abstract, generalised and de-contextualised from specific situations and events" (ibid., p. 4). Together, episodic and semantic knowledge form a person's *world knowledge* (ibid., p. 4). Flick (2014) explains that episodic interviews with narrative passages collect narrative-episodic knowledge using narratives, while semantic knowledge is made accessible by concrete pointed questions (p. 274).

The episodic interview captures *small-scale situation narratives* within the sequences of questions, rather than larger biographical *lifespan narratives* (Flick & Rönsch, 2014, p. 1098). Through the process of reflective narration, the meaning of the interviewee's experience of the episodic situation can become explicit (Flick, 1997). What is important to note is that the experience itself does not have a narrative structure, but rather it is constructed "in form of a narrative" (ibid., p. 3).

The scheme of an episodic interview is *semi-structured* [73]. A semi-structured interview allows the researcher to respond flexibly to the interviewee and ask additional questions when needed for clarifications (Meuser & Nagel, 2009). This structural flexibility was a relevant aspect of my data collection since it would not have been feasible for me to return to some of the interviewees of the Music and Dementia projects.

When it comes to the process of interviewing, after a *preparation phase* [74], the episodic interview consists of the following seven phases (Flick, 1997 pp. 5-11):

Phase 1) Introduction: the episodic interview begins with the interviewer introducing the principles of the interview and emphasising that the focus is on narratives of lived situations (ibid.).

Phase 2) The interviewee's understanding of and biographical relation to the research topic: the researcher asks questions that help the interviewee to enter the topic and to give their *subjective definition* of it (ibid.). This approach helps the interviewer to find out the interviewees' preconceptions of the narrated-upon topic. The main principle of the episodic interview is to ask the respondent to remember *specific situations* (ibid.).

Phase 3) The meaning of the research topic: the researcher concentrates on *issues of meaning* that are central to the study (ibid.). The researcher in this phase is interested in what the interviewee's relation is with the topic at hand and what kind of meaning the topic has for them in their everyday life.

Phase 4) Focused questions about the central aspects of the research: the researcher concentrates on specific questions that aim to help the interviewee *deepen their narration* of their personal relationship to the central aspects of the research as substantially as possible (ibid.).

Phase 5) General questions: there is a place in the episodic interviewing scheme for more general questions about the subject of the study that aim for *enlarging the interviewee's scope*

73 Semi-structured interviews have an open approach that allows the interviewee to narrate in their own way and at their own pace (Meuser & Nagel, 2009; Kvale, 1997). During the interview, the interviewer holds a list of topics to which s/he wishes to get responses yet sequences the questions and distributes time and attention on the topics with considerable freedom (Robson & McCartan, 2016, p. 290).

74 The preparation is based on the researcher's preliminary theoretical and empirical understandings of the research topic (ibid.). The preparation for my data collection was informed by and based on the preparational period described in section 4.1.3. Also, the preparation phase of my research included the recruitment of the research participants and ensuring that they were well-informed about the study (see later section 4.4.1.1).

of narration. The researcher, then, attempts to find connections to more general and often more abstract narrations that emerge in this phase of the interview with the previously narrated personal accounts (ibid.).
Phase 6) Evaluation and small talk: At the end of the interview, the interviewer offers space for further remarks by asking additional questions that allow the interviewee to *complement the previous narrations* in an informal "small talk" manner (ibid.).
Phase 7) Documentation: The researcher contextualises the interview in notes and reflects upon it immediately afterwards. The tape-recorded interview (see also section 4.4.2.2) will then be transcribed verbatim (ibid.). After these phases, the analysis process begins.

4.3.2. Group discussion

Within the framework of this research and in line with Wenger (1998), knowledge is understood as co-constructed within learning communities (see section 3.2.2). To find out how healthcare professionals *negotiate meaning* about the participatory music practices within communities of practice, the second primary source of data of this research was group discussions. The group discussions were held at the end of each observed music project in both care contexts. The reason for using group discussions was to hear the collective voice of healthcare professionals as a community. In this research, the group discussions were deemed necessary because the healthcare professionals' daily work was based on teamwork and collaboration. According to Bohnsack, Przyborski and Schäffer (2010), group discussions reflect the emerging collective opinions of a group without focusing on the expression of individual opinions. Thus, group discussions can serve research that is interested in the attitudes, opinions, discourses, values and practices of people in a particular social context.

There are two fundamental considerations when approaching group discussions (Bohnsack, 2004). First, that the group discussion is centred around the interactions in the participants' social context, and second, that the participants are representing a group that is homogeneous according to the main criteria of the research (e.g. profession, education) (ibid.). A group discussion usually involves a small number of individuals discussing topics or phenomena together with a discussion moderator (Bohnsack et al., 2010). The moderator has two main responsibilities: first, to keep the discussion close to the topic of interest and second, to facilitate the group to discuss fluently (Robson & McCartan, 2016, p. 301). The moderator must, therefore, create conditions for the group to reveal its own *structural identity* in the process of the discourse, so that the discussion represents the group's experientially based "collective orientation framework" (Bohnsack 2004, p. 219).

According to Bohnsack (2004), there are eight main principles of the group discussion (p. 220):

1) The whole group is addressed in the discussion together and not as individuals.
2) The moderator's first questions are intended to *initiate conversation*, instead of steering how the topic should be discussed.
3) The sequences of questions are intentionally open.
4) Ideally, follow-up questions are presented only when the participants stop taking turns to talk.
5) The questions (and follow-up questions) are framed in a way that they are able to

generate detailed narratives.

6) The moderator gives priority to follow-up questions that are within the framework of the discussion, rather than those which initiate new topics.
7) Only after all the most relevant topics for the group and the researcher have been discussed, new questions relating to other topics may be introduced if needed.
8) At the end of the discussion, the moderator may ask additional questions about striking or contradictory statements.

4.3.3. Participant observation

The third data collection method in my research was participant observation. Participant observation is a method in classical ethnography (Atkinson & Hammersley, 2007; Bisschop Boele 2013). It has been defined in many ways, such as active looking, systematic description of behaviours and artefacts in social situations, and written photography (Kawulich, 2005). Participant observation is considered as a "flexible, methodologically plural and context-related" approach of data collection (Lüders, 2004, p. 224). It is characterised by nonlinear procedures that require the researcher to keep a non-judgemental attitude, to observe and listen carefully, and remain open to experiencing unexpected situations (Kawulich, 2005).

Participant observation enables the researcher to identify, interact and build relationships with the people s/he is studying and understand the culture and social structures using an *emic* perspective (Bresler, 1995; Krüger, 2008). Fetterman (2008) explains that emic perceptions can be understood as shared views of cultural knowledge from the perspective of the members within the social establishment. Therefore, an emic perspective is "fundamental to understanding how people perceive the world around them" (ibid., p. 249). As such, an emic perspective is essential for qualitative research (ibid.). Participant observation can be seen as complementary to data collection of narrative accounts, as it allows the researcher to see and hear what people do and say directly in the social situation s/he is witnessing. Furthermore, participant observation enables the researcher to connect concepts that participants describe in interviews to observable situations (Kawulich, 2005).

The primary way of capturing data through participant observation is writing ethnographic fieldnotes (Emerson, Fretz and Shaw, 2011). Writing down turns the passing events into descriptions of episodes that can be re-consulted (ibid.). Subsequently, the first interpretations of the events captured in the fieldnotes link the data collection and the analysis closer together, as the researcher can revisit fieldnotes when formulating deeper interpretations of the studied situations (ibid., p. 17).

As a further means of documentation, participant observations can be supported by participant audition[75]. Interview situations are known to restrict accounts of social action, whereas participant audition can capture accounts within the setting of the interactions, where the meaning is primarily constructed (Meyer and Schareika, 2009, pp. 14, 24). Participant audition was used as a supportive measure for participant observation within the MiMiC pilot projects.

75 According to Meyer and Schareika (2009), participant audition, in other words, the use of audio recordings in ethnographic research, helps the researcher to hear the voices of the 'local people' (p. 4). So, participant audition helps the researcher to reconstruct their interpretations of the studied phenomenon in a way that is close to the expressed experiences of the participants.

4.4. Data collection: a processual description

In the following sections, I will describe the process of data collection of this research. At the beginning of the process, the professional life in the context of hospitals and nursing homes was fairly unfamiliar to me. Therefore, it was critical to give primacy to how healthcare professionals reflected, individually and collectively, on their experiences of the music sessions in their own words within the culture and context of their work. The participant observation data, thus, can be considered as an approach to positioning the interview and group discussion accounts into observable social situations contextualising the narrated experiences into a descriptive and interpretative research output.

4.4.1. Strategies for sampling: criteria and recruitment of expert participants

After conducting my forestudy in 2015-2016, as well as the two pre-pilots of the MiMiC practice in 2015 (see sections 2.1, 2.3.1.1), I had created the *initial sampling criteria*[76] for data collection. The criteria for sampling were that the participants should be healthcare professionals and also, working in the context of and during the two empirical studies. The reason for this was that I aimed to collect *expert accounts* through interviews and group discussions. Expert research participants bring insight to the research that arises from their practice-related expertise, not only theoretical knowledge (Alasuutari, 1999, pp. 270-271). Another criterium was inclusion, meaning that I was endorsing the selection of participants with diverse job titles, experience levels (*newcomers* and *old-timers* after Lave & Wenger, 1991), and professional viewpoints.

After establishing the initial sampling criteria, I began *theoretical sampling*[77]. However, instead of following an inductive approach to theoretical sampling, which is typical for sampling in classical grounded theory research, the sampling of my research was abductively *selective* per observed project. Although I continuously aimed to sample as diverse views as possible until reaching a saturation of the data (see section 4.4.3), I based the sampling on the participants' observable engagement in the music sessions (see section 4.4.1.1). I did it to ensure collecting expert accounts of healthcare professionals who had first-hand experience of the music sessions.

Due to practical constraints of sampling, e.g. nurses' unpredictable work situations and complex rotas, the collection of expert accounts would otherwise have been uncertain. Thus, although I sampled with the intention of 'optimal contrast' in order to ultimately reach a middle-range theory, I needed to employ a form of *purposive* sampling (see also *purposeful* sampling) to carefully handpick participants who were able to contribute "information-rich" data (see Patton, 1990, p. 169) given the contextual limitations of the study. According

76 Grounded theory research starts with a process called *initial sampling* that establishes the criteria for the selection of participants or cases at the very beginning of the research (Charmaz, 2006, p. 100). Initial sampling is needed as one cannot assume to know the analytical categories of the research in advance (Schreiber, 2001).

77 Theoretical sampling is a process of data collection for generating theory "whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Untamala, 2014, p. 62). Theoretical sampling starts with an empirical enquiry, which leads to constructing speculative ideas based on the collected data, and again returning to enquire deeper on these ideas through further data collection (Charmaz, 2006, p. 102). Charmaz (2006) explains that theoretical sampling ensures that the researcher constructs full and robust categories (p. 103).

to Barglowsky (2018), purposive sampling "relies on [the] researcher's judgment to select participants with diverse characteristics" (p. 166). Such an abductive approach to sampling requires reflexivity (see also section 4.1.4). In some of the observed music projects, the number of expert participants meeting the sampling criteria was small enough for me to be able to include all of them in the study.

4.4.1.1. Recruitment process

MIMIC

In the MiMiC practice, participant recruitment began with contacting the head of the hospital ward (head nurse) before the beginning of each observed project. Through the head nurse of each of the three wards, I sent an informational letter to all the healthcare professionals working in the wards about the aims of my research (see Appendix 1.A.) I also had a chance to visit the wards before the projects started to personally introduce the healthcare professionals to my research. These initial moments of contact with healthcare professionals were supported by the UMCG-partners of the MiMiC research team.

During the data collection process for the MiMiC practice, after the first round of data collection for the second pilot project in October 2016, I changed my initial sampling strategy, which had allowed the ward's head nurse to choose the research participants according to the unit's working schedules. Instead, I started selecting expert participants based on the healthcare professionals' participation and involvement in the music sessions (*theoretical sampling)*. The reason for this fundamental change from initial sampling to theoretical sampling was that I noticed that the quality of data depended on the level of the healthcare professionals' participation in the music sessions; those who had been on-site during the project more often than others were able to give richer accounts of their experiences[78]. Hence, I started to purposefully approach individuals whom I had observed taking part in the music sessions during the project.

I aimed to reach any healthcare professional that had agency in the music projects without excluding anyone based on their professional position in the ward unit. Thus, I was not only collecting accounts from nurses or specialist nurses (i.e., professionals in the higher-ranking positions of the hierarchical care community) but rather, any member of the care community who had participated in the music sessions. I personally asked those ward staff members to participate in the interviews and group discussions, which would be held at the end of each project. Finally, I booked these 'purposefully selected' interviews and group discussions with the help of the head nurse so that they (a) fit within the ward's care schedule, and (b) would disturb or interfere with the care as minimally as possible.

78 The first interviews for the MiMiC practice that were set up by the head nurse were significantly shorter and less insightful (the shortest only 23 minutes) than the following interviews using a purposive sampling strategy. Flick (1997) states that the length of episodic interviews "varies according to the number of questions prepared, depending on the interviewee's readiness to recount and the skill of the interviewer to direct the interviewee towards detailing and comprehensiveness in his or her narratives" (p. 13). In this research, it seemed that the interviewees' readiness to recount musical situations was crucially limited by not having been in the workplace enough during the time of the music project.

MUSIC AND DEMENTIA

The two organisations providing Music and Dementia projects employed project managers as the initial point of contact between the nursing home care staff and the musicians. Therefore, for my initial requests for conducting research on the Music and Dementia projects that were run by these providers, I first got in contact with the project managers for approval on behalf of their organisations. Upon approval, the project managers then introduced my research request to the care managers and coordinators of the care units in which the projects would take place. When given permission by care management, I was able to contact the nursing home managers to get in touch with the caregivers who would participate in the music projects. I approached the caregivers via email with an informational letter about the research interviews and group discussions (see Appendix 1.B.). Although it was not possible for me to brief them about the research in person before each music project due to a combination of the chain mechanism of communication and geographical distances, all caregivers involved in the Music and Dementia projects whom I contacted consented to my request to be interviewed.

In the Music and Dementia practice, each eight-week-long project engaged approximately eight caregivers as participants in weekly music sessions. The caregivers were initially chosen to participate in the projects by the care managers of the respective nursing homes. Only members of the caregiving workforce were recruited to the projects instead of, for example, volunteer workers. Each session had three caregivers in the circle and, therefore, the caregivers took turns participating in the circle of the practice and observing outside the circle. As the number of the participants was smaller and more focused per project compared to the MiMiC practice, where any member of the ward staff could join the music sessions, I asked to interview at least two participating caregivers once mid-way through the project and once at the end of the project. I also asked a maximum of five caregivers, whom I had observed in the circle from the beginning until the mid-way point of the project, to take part together in a group discussion at the end of the project. This approach was part of the 'purposeful strategy' of recruiting expert participants into the theoretical sample, leading to the saturation of data and ultimately, to a middle-range theory (see sections 4.4.3, 4.5.5.3).

4.4.1.2. Main features of the sample

SAMPLE SIZE

I collected 18 individual interview accounts, four group discussions and 26 observations for the MiMiC sample, and I collected 11 individual interview accounts, five group discussions and 18 observations for the Music and Dementia sample. See the overview of data collection in tables 1 and 2 below.

The length of the captured narrative data varied, with the longest interview being 78 minutes and the shortest only 23 minutes. The interviews and group discussions tended to be longer in the Music and Dementia context (average length of interviews 37 minutes and group discussions 42 minutes) than in the hospital context of MiMiC (average length of interviews 30 minutes and group discussions 32 minutes). This difference may be explained by factors that will be presented later in sections 4.6.1.1-4.6.1.3).

SAMPLE OF THE MIMIC PRACTICE

Due to the inclusive selection strategy of theoretical sampling in the MiMiC practice, participants held various professions. They included care assistants, nutritionists, nurses, coordinating nurses, specialist nurses, a social worker, a doctor-in-training and a physiotherapist. Therefore, group discussions brought forward reflections from the perspectives of different caregiving professionals as a diverse community rather than hearing the collective meaning-making of just one group of professionals.

In the MiMiC practice, an overwhelming majority of the participants were women. Only five respondents were male, holding different positions (nurse, specialist nurse, coordinating nurse and physiotherapist). Furthermore, the musicians' interactions and collaboration mostly happened with female members of the nursing workforce. The physicians of the wards had limited interaction with the musicians, although they were not excluded from the observations during the music sessions.

Table 1. Data collection in context 1: Meaningful Music in Healthcare practice (MiMiC) on surgical hospital wards of the UMCG.

Timeframe and department	Data collection
Date: 17 - 23 September 2016 Traumatology	No data collection. Taking part as a musician.
Date: 24 - 30 October 2016 Vascular and Hepatobiliary Surgery	Seven participant observations, one group discussion (four participants), four episodic interviews with narrative passages (four interviewees)
Date: 28 November - 4 December 2016 Oncological Surgery	Seven participant observations, one group discussion (five participants), four episodic interviews with narrative passages (four interviewees)
Date: 16 - 22 January 2017 Oncological Surgery	No data collection. Taking part as a musician.
Date: 27 February - 4 March 2017 Traumatology	Six participant observations, one group discussion (three participants), five episodic interviews with narrative passages (five interviewees)
Date: 8 - 13 May 2017 Vascular and Hepatobiliary Surgery	Six participant observations, one group discussion (two participants), four episodic interviews with narrative passages (four interviewees)
Date: 27- 30 July 2017 Vascular and Hepatobiliary Surgery	Taking part as a musician. One additional episodic interview with narrative passages (one interviewee) on 29 July, 2017

SAMPLE OF THE MUSIC AND DEMENTIA PRACTICE

As most of the caregivers held similar job titles, there was less occupational diversity in the Music and Dementia sample than in the sample of the MiMiC practice. This was a significant difference regarding group discussion participants between the two practices. Furthermore, in the context of the Music and Dementia practice, all research participants were women. Although the homogeneity of gender was a feature of the sample, I did not

assume gender to have analytical relevance for the findings unless it would have emerged as such (see also Untamala, 2014, p. 55). Thus, this research does not have a particular focus or perspective on gender. Yet, it cannot be ignored that the field of (elderly) healthcare is overwhelmingly dominated by female workforce (see Evans, 1997; Zhang & Liu, 2016). Thus, it can be reasoned that the gender representation of the sample reflects the reality of gender imbalance in caregiving professions, which could most likely not have been influenced by changing the sampling strategy.

Table 2. Data collection in context 2: Music and Dementia practice in nursing homes.

Timeframe and place	Data collection
Date: 18 January - 7 March 2016 Place: Nursing home in Purmerend in the province of Noord-Holland	Seven participant observations, two group discussions (five participants and two participants), five episodic interviews with narrative passages (three interviewees).
Date: 14 October - 6 December 2017 Place: Nursing home in Hoogkerk in the province of Groningen	Eight participant observations, one group discussion (two participants), four episodic interviews with narrative passages (two interviewees).
Date: 16 November 2018 - 25 January 2019 Place: Nursing home in the Rotterdam in the province of Zuid-Holland	Three participant observations, two group discussions (four participants and two participants), two episodic interviews with narrative passages (two interviewees).

REFERENCE TO THE SAMPLE IN THE DATA ANALYSIS

As explained previously (see section 1.7), for the benefit of contextual clarity in the analysis of this research, I am henceforth going to refer to the various healthcare professionals participating in the MiMiC practice as 'nurses'[79], which represents the vast majority of the participants in the first empirical study. I will refer to the healthcare professionals participating in the Music and Dementia practice as 'caregivers', which is also representative of the main job titles of the people taking part in the second empirical study.

The thick description may incidentally include isolated job titles that do not fit to this contextual distinction of nurses and caregivers. Such job titles are coordinating nurse, doctor-in-training, physiotherapist, social worker, nutrition assistant and activity leader. I will refer to these titles incidentally as they appear in the analysis. Finally, when referring to all research participants from both music practices together, I will use the all-encompassing term 'healthcare professionals' in line with the title of this research.

LANGUAGE USED IN SAMPLING

All participants in this research were native Dutch-speakers. So, all interviews and group discussions were held in the Dutch language. As a non-native Dutch-speaker, my flexibility

79 For the sake of analytical clarity, I have referred to the participants in the MiMiC practice as 'nurses' also in my previous contribution to the already published qualitative research on the MiMiC practice "If Music be the Food of Love, Play On" (see Smilde et al., 2019).

of probing in the interviews and group discussions was limited at the beginning of the data collection. As the data collection progressed, my Dutch fluency improved, which allowed for more nuanced possibilities to probe the same questions in different ways.

In the analysis process, I coded Dutch language raw data and only later translated those passages to English that were crucial for the conceptualisation of the theory formation (see section 4.5.2.1 on Initial coding). Although the raw data was in Dutch, I wrote my reflexive research memos in English. This step helped me to formulate my theory directly into an English language dissertation (see section 4.5.1 on Memo-writing).

4.4.2. Settings, schemes and procedures of data collection

4.4.2.1. Settings

As previously explained, the data collection was set up differently between the two empirical studies. Because the MiMiC practice took place in week-long projects, the nurses were interviewed once each after the project had finished. In Music and Dementia, however, each project lasted eight weeks, so each caregiver could be interviewed twice during this period: once in the middle of the project and once at the end of the project. The group discussions took place at the end of each project in both practices.

Participant observations took place in the workplace of the healthcare professionals during their working hours, while interviews and group discussions were held either just before, during or after their work shifts. Typically, the interviews took place in a staff break/meeting room or in a family meeting room of the care unit. These spaces were usually furnished with a set of chairs and a table, around which the interviews and group discussions were set up. The workplace as a setting for episodic interviews, especially in the hospital context, was sometimes unpredictable, which could interfere with the participants' concentration. Distractions, such as being paged or interrupted by colleagues, however, rarely happened during the interviews.

4.4.2.2. Schemes and procedures of episodic interviews with narrative passages

I followed the episodic interviewing scheme as carefully as possible (see section 4.3.1). During the introduction of the interviews, I explained aspects of confidentiality, the purpose and interest of knowledge of the research, as well as the nature of the interviews to the interviewees. I emphasised the openness of the questions and that there were no expectations of objectivity in their personal accounts. I was also transparent about my position in the research by introducing myself, my professional discipline, and by stressing to the interviewees that everything that was important for them to tell was relevant for me to hear. Before starting to record the interviews on a Zoom-audio recorder, I obtained informed consent via signed consent forms (See Appendix 2). By signing the form, the interviewees granted me a permission to record, use and quote their accounts in this dissertation. Only after the consent forms were signed, I asked if I could begin the audio recording. Audio recordings were destroyed after the interviews were transcribed.

In semi-structured episodic interviews, the order of the questions was flexible and specific questions could be added to individual interview plans, based on each participant's

particular interactions and participation in the music sessions. I began probing with a warm-up question and continued with biographically inclined questions about the interviewee's working life and musical biography. Afterwards, I proceeded with episodically specific questions about the music project and moments that stood out in the music project for the interviewees. Subsequently, I asked episodic questions about participation, communication and emotions in the musical situations. These were deepening questions about the meaning connected to the narrated episodes. The following phase of general questions, designed to enlarge the scope of the narration, were centred around aspects of learning and the meaning of the music project for the interviewees' work and well-being. See the full list of questions in Appendix 3.A.

As advised by Flick (1997), I ended the interviews with a small talk-like situation. I noticed that in this small talk phase, some participants corroborated what they had already narrated in their accounts, but this time in a more informal and personal manner than when answering to the interview questions.

4.4.2.3. Schemes and procedures of group discussions

The number of participants in the group discussions of both MiMiC and Music and Dementia samples varied between two to five persons per group, based on the nurses and caregivers' availabilities. As the moderator of the group discussions, I aimed to steer the discussion as minimally as possible by employing careful *topical steering;* bringing up topics of discussion that were relevant for the research. However, I noticed that my role became more prominent than I had intended in most of the group discussions, especially in the hospital. The reason for this was that, often, the discussion needed more specific questions to stimulate the responsiveness and continuation of the conversation.

I began the group discussions first by explaining the principles of the discussion including interest of knowledge, aspects of confidentiality and use of data. I again explained my position in the research and emphasised that I intended to interfere with the discussions as little as possible. I collected informed consent forms before starting to audio-record the discussions. Then, I introduced a *generative narrative opening*, where I presented a "provocative story" that was intended to stimulate conversation. In later group discussions, the provocative story could stem from a remarkable statement connected to a previous group discussion or an interview, or a situation during one of the observed music projects. At the end of the generative opening, I asked: "How do you relate to what you heard in the story?"

Afterwards, when the discussion started, I asked episodic questions about musical situations in the project that had significance for the work colleagues. I continued to probe the collective meaning of the music project, including contact with patients, musicians and colleagues, staff participation in the sessions, emotional resonance and impact of the music-making, well-being, teamwork and collaboration, as well as learning processes and new insights. I allowed space for each group discussion to end with a small talk-like moment to enable additional reflections and remarks to be voiced. See the full list of the group discussion topics in Appendix 3. B.

4.4.2.4. Schemes and procedures of participant observation

In this research, participant observation focused on the healthcare professionals' observable participation in the music projects, which included their interactions with patients, colleagues and musicians.

PARTICIPANT OBSERVATION ON THE MIMIC PRACTICE

In the context of MiMiC, I observed two seven-day and two six-day projects on a daily basis. I started each observation in the nurses' breakroom where the musicians played for them. Then, I observed a briefing meeting among the musician team and the coordinating nurse. Afterwards, I followed every visit into the patients' rooms, when possible. When the situation was too delicate for me to be present, I stayed outside the room and observed from afar. In these situations, it was helpful that the sessions were audio-recorded, as the participant audition captured such conversations during the musical visit that I was unable to hear from the distance. Finally, I observed the debrief meeting among the musician team and the coordinating nurse after the music session ended. In total, I observed approximately two hours of social interactions per day.

The nurses participated in the sessions by the bedside of their patient, by standing at the doorway to the patient's room or outside the room in the corridors. At times, they had to leave during a piece when they were paged. Therefore, it was necessary to capture even small gestures of engagement in the nurses' participation. I did this by making brief hand-written ethnographic fieldnotes with key words and short descriptions on the spot and based on them – aided by the audio-recordings – I composed my daily observation reports.

PARTICIPANT OBSERVATION IN THE MUSIC AND DEMENTIA PRACTICE

In the context of the Music and Dementia practice, I observed each hour-long music session outside the circle, where the music-making happened. During my observations, I made hand-written fieldnotes continuously throughout the session. I also used a drawing of the participants' seating arrangement to help me link the written social actions to the right participants and their names (which were later redacted). I also observed the debrief sessions, which were shared between the musicians, project managers and caregivers. In total, I observed two hours of interactions per project day. At the end of the observations, I composed my observation report based on the fieldnotes. In one of the three Music and Dementia projects, I was participating in the role of a musician, which made taking fieldnotes 'on the spot' impossible. For those sessions, my observation reports were supported by notes written down immediately after the sessions.

MAIN DIFFERENCES BETWEEN PARTICIPANT OBSERVATION IN MIMIC AND MUSIC AND DEMENTIA

My approaches to participant observation in the two empirical studies had three notable differences. First, the fieldnotes needed to be written differently in MiMiC than in Music and Dementia, due to ethical reasons: in patients' hospital rooms, it would have been inappropriate to write notes in the proximity of the patients and the nurses. Thus, fieldnotes

in MiMiC were written in between visits to patient rooms on several occasions. In Music and Dementia, being outside the circle allowed notes to be taken in real-time, as the participants were undisturbed by the writing while engaged in the music-making in the circle.

Second, audio recordings were only made in the MiMiC practice. I deemed making audio recording unnecessary in Music and Dementia because I was able to write more extensive fieldnotes 'on the spot' than in the MiMiC practice, as I was seated right outside the circle of residents, musicians and caregivers, where I could continuously write notes. Thus, I was able to rely on my extensive fieldnotes alone when processing the observation data on the Music and Dementia sessions. Also, my observations were supported by the conversations during the collective reflection moment right after the music session, where the musicians and caregivers recapitulated all of the main processes of the music-making.

Third, the participation of the healthcare professionals had significant differences between the two practices: in Music and Dementia, the caregivers would sit close to the residents during the full hour-long session, whereas in MiMiC, the nurses' participation could vary significantly in terms of proximity and duration. These differences will be described in chapter 5 on Analysis.

4.4.3. Towards the saturation of the data

By the end of the second Music and Dementia project at a nursing home in Hoogkerk (December 2017), it seemed that the data collection was reaching *saturation*. Saturation is a crucial determinant of the sample size (Rudestam & Newton, 2007) because when the theoretical categories have reached saturation, gathering new data no longer sparks novel theoretical insights, "nor reveals new properties of these core theoretical categories" (Charmaz, 2006, p. 113). When a kind of saturation has emerged in the theoretical sampling, meaning that the researcher mainly receives already known statements, the final core categories will be formulated and theorised by the researcher (Untamala, 2014).

In my research, the saturation emerged when the given reflections and observations were in line with the previous ones, and no new remarks were made during the interviews and group discussions. By the midway point of the third Music and Dementia project in Rotterdam (December 14th, 2018), it seemed that the data was indeed saturated to the point where no new insights emerged. Rather, confirmative statements were made, which helped fill in and enrich the already made observations.

The last round of data collection took place in a nursing home in Rotterdam on January 25th, 2019. Following the constructivist grounded theory orientation that emphasises studying an experience "from the standpoint of those who live it" (Charmaz, 2000, p. 522), by the final visit to the nursing home, I felt that I had gained a robust enough view of healthcare professionals' experiences to be able to bring my interpretations of the data into thick description. At the core of what grounded theory is about, by the end of the data collection there were significant similarities and also substantial differences in the data collected from the two empirical studies.

4.5. Data analysis through grounded theory construction

In grounded theory, after empirical data is collected, the coding and categorising of data starts immediately to "reflect the various issues represented" in it (Jones & Alony, 2011, p. 104). The categorising happens through naming segments of data, which concurrently summarises and catalogues each piece of data (Charmaz, 2006, p. 43). As the codes are closely linked to the data they serve as the first step towards an analytical and conceptual interpretation, and so, coding can be understood as the backbone of the analysis and the theory formation (ibid.). The coding process is supported by memo-writing, which serves to capture comparisons and connections in the process of theory formation, and eventually lead to the materialisation of the theory on paper (ibid.).

4.5.1. Memo-writing as an analytical tool for theory formation

During the process of theoretical sampling and data analysis, memo-writing, or *memoing*, is a crucial analytical tool through which the researcher writes texts that may link the references to theory and the fragments of empirical data together (Corbin & Strauss, 2008). The fundamental goal of memoing is to develop ideas and codes freely and to help the researcher make sense of the data (Jones & Alony, 2011, p. 106). The aim of memoing is to structure and contextualise concepts arising from coding. In doing so, the analysis becomes explicit, and therefore, memo-writing is "the pivotal intermediate step between data collection and writing drafts of papers" (Charmaz, 2006, p. 72; Charmaz & Mitchell, 2007). In memoing, the length, grammar or content are not important (Untamala, 2014). Instead it is essential to have a large collection of memos to support the theory formation. Untamala (ibid.) explains that instead of focusing on how to write, "one should concentrate on what to write" (p. 61).

In line with Untamala (2014), I wrote memos that were free from a formal style of writing to best serve the emergent development of my conceptual interpretation of the data. Only later, when I was reconstructing the interpretations into a thick description, I started rewriting the memos into a formal presentation. I wrote the majority of my memos on the Atlas.ti programme[80], as it allowed me to shift between the coding and the memoing effortlessly and simultaneously. I found memoing important for gaining a sense of *data intimacy:* a close familiarisation with significant patterns, categories and plausible meanings of the data (see also Saldana, 2011, p. 95).

4.5.2. The step-by-step process of coding in constructivist grounded theory

The coding canons of grounded theory can be divided into *First Cycle* and *Second Cycle* coding methods (Saldana, 2009, p. 42). In the first cycle coding, the data is coded into individual segments (ibid.). In the second cycle, the coding processes constantly compare, focus and reorganise the codes into categories that are connected to a central core category, which is the foundation of the empirically grounded theory (ibid., p. 42). Following constructivist grounded theory conventions, I carried out the coding process in two main stages: *initial*

80 See a description of the coding process using the Atlas.ti programme later on section 4.5.2.1 on Initial coding.

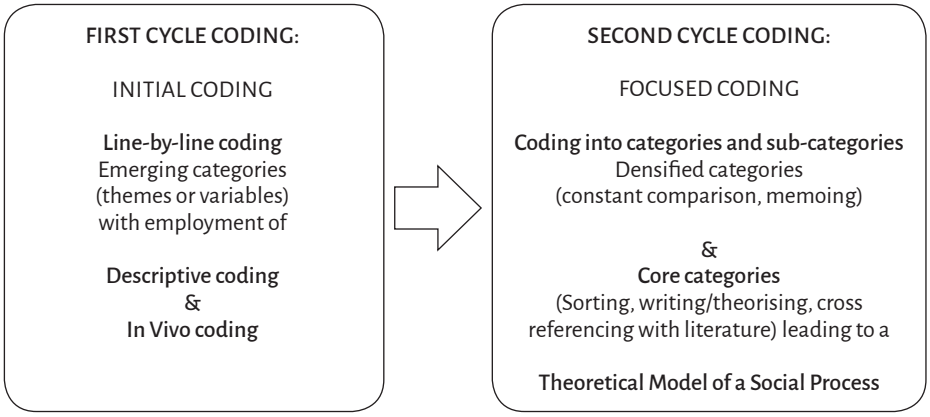
coding (first cycle coding) and *focused coding* (second cycle coding) (see also Charmaz, 2006).

In the stage of *initial coding*, the qualitative data is broken down into parts that are named and compared with each other. The researcher may decide to code the data word-by-word, line-by-line, segment-by-segment or incident-by-incident (Charmaz, 2006; Saldana, 2009). The level of coding precision helps the researcher to remain open to all possibilities of theoretical directions where the data may lead to (Charmaz, 2006).

The following stage of *focused coding* is a more directed, selective and conceptual phase of coding than initial coding. Charmaz (2006) explains that focused coding requires identifying the most analytically significant individual codes in the data and making decisions on how to categorise them (p. 57). Technically speaking, focused coding helps to develop a "sense of categorical, thematical, conceptual and/or theoretical organisation" of the first cycle codes based on their inter-relationality or similarity (Saldana, 2009, p. 149).

The final step in the second cycle coding is the central development of the grounded theory formation: identifying the core category or categories that integrate the full analysis into a theoretical model. In this research, I employed the following approaches to first and second cycle coding (see following sections 4.5.2.1-4.5.2.3):

Figure 3. The process of grounded theory coding in this research after Charmaz (2006).



4.5.2.1. Initial coding – Line-by-line coding using Descriptive and In Vivo coding

In the phase of initial coding, I created 837 codes from the raw data using the Atlas.ti coding programme. For every coded document, I had a separate memo-document, where I highlighted the main conceptual discoveries in every interview, observation report or group discussion. In the line-by-line coding, I employed mostly *descriptive coding* (Saldana, 2009) where the codes summarise "in a word or a short sentence – most often as a noun – the basic topic of a passage of qualitative data" (p. 70).

Furthermore, in some passages of the line-by-line coding, I also used *In Vivo coding*. In Vivo coding refers to the actual language used in the data by the participants themselves (Charmaz, 2006; Saldana, 2011, 2009). These In Vivo codes serve as *symbolic markers* of the participants' meaning-making (Charmaz, 2006, p. 55) and emphasise the originality of

their voices in the research (Saldana, 2009). In this research, I used In Vivo coding when it was the most appropriate way to categorise the participants' authentic statements of their experiences, such as "*Zen*", "*Goosebumps moments*", or "*I found that beautiful to see*".

4.5.2.2. Focused coding – From code families to theoretical core categories

After the initial coding phase, I was able to organise the loose codes from the line-by-line open coding into code families. At this point, the code families did not yet have any hierarchical organisation. I visualised the categorisation of the code families in multiple versions of mind map-like drafts until I was convinced that they formed a credible representation of the coding. The eight code families under which the most consistent initial codes were grouped were:

Table 3. Coding of code families during focused coding.

Code families	Codes within the code families
BACKGROUND (Partly individual and personal, partly "state of play at the beginning", forming conditions of participation)	Familiarity of music Relationship with (classical) music Understanding of one's own musicality Attitude and motivation at start Curiosity, mindset, openness at start Personal preferences of music Support at work to participate, encouragement to participate Having time to participate (or lack of it) Being sufficiently informed (or lack of it), Not knowing what to expect Situation at work Levels of staffing
PARTICIPATION (describing healthcare professionals' actions, agency and processes of participation)	Professional distance Feeling responsible to "be there" for/with own patient Allowing oneself to participate Apprehension to participate Fear of participation Observing Listening Singing along Playing instruments Helping patients to participate Being invited/encouraged to participate by colleagues Collective, shared action Collaborating with musicians Presence By-hearing, by-listening Being by the patient Dwelling, being legitimately peripherally there (Understanding of one's) own role in the project

table continues

Code families	Codes within the code families
LEARNING	Reflection on ways of working (professional development) Reflection on person-centred communication with patients Reflection on teamwork and collaboration with musicians Reflection on musicians' professional skills Learning from musicians' approaches to initiate contact Change of attitude towards music at work Growing motivation of musical participation Growing appreciation of classical/instrumental music Gained musical understanding Gained new strategies for the use of music at work Articulated plans to apply new knowledge Awareness of the meaning of live music for work
COMMUNICATION AND INTERACTION	Music as a catalyst for communication, Gaining "access" to patient Deepening care relationship through music Increased interaction among patients Increased interaction between healthcare professional and patient Seeing one's colleagues communicate differently Breaking down social hierarchy among colleagues Shared experiencing Sense of personal contact and attention Feeling of inclusion Feeling of recognition and respect Feeling of intimacy and closeness Perceived kindness in musicians' communication
EMOTION	Seeing new emotional sides and responses of colleagues Seeing new emotional sides and responses of patients Becoming emotional for the other Empathising with the patient's situation (pain, sadness, lost control) Putting the patient's musical needs first Joy for the patient's enjoyment, Sympathetic joy Feeling fulfilment for patient's positive musical experience, "I found it beautiful to see" Displaying compassion, delivering compassionate care through music Letting oneself be emotionally vulnerable Acknowledging one's own emotional responses to music "Goosebumps moments" Appreciation and respect towards musicians Gratitude for the musicians' attention to and recognition of the staff members Gratitude for the perceived kindness of musicians
ENVIRONMENT	Change of atmosphere Transforming the experience of environment Imagination, musical imagining, transportation Accompaniment to work Mood of environment (calm, energetic, uplifting) Perception of time, Kairos Feeling the music entering oneself, "It enters"

table continues

Code families	Codes within the code families
RESOURCES (JOB- AND PERSONAL)	Concentration Being in the now, Mindfulness Breaking routine, distraction from hecticness Growing relaxation, "Zen" Gained energy at work Increased joy and satisfaction at work Gaining contact with patient Gaining new insight into patient Increase of patients' acceptance of care Music supporting the recovery of patients
VALUES	Value of person-centredness, personal attention to and recognition of patient Value of the patient's experience of the musical interactions Value of collaborative way of working Value of (taking) time, presence Values of compassion and emotions in care

4.5.2.3. The emergence of the core categories

When the final core categories are becoming apparent, they should be capable of telling "the story of the case" derived from the empirical study (Smilde et al., 2014, p. 41). A core category should have a clear and meaningful relationship with the other categories, as well as a substantial quality (Jones and Alony, 2011, p. 107). It must not only relate to the other categories but also, it needs to appear frequently in the data and accommodate maximal variation of the analysis (Alvesson & Sköldberg, 2018, p. 87). As such, the core category establishes the focused theoretical perspective of the research (Untamala, 2014, p. 57).

I was able to find hierarchies between the code families through memoing and reflection. The final core categories emerged "on top" of the other sub-categories of codes. I came to understand that experiencing through participating was in the foundation of the theoretical body of the research. The emerging three core categories of this grounded theory research are, thus, *Participation*, *Experience* and *Learning benefits*. The theoretical core categories have been conceptualised in dialogue with the literature described in the conceptual framework of this dissertation (see chapter 3). The analysis and findings on these core categories will be presented in chapter 5 on Analysis. See below the full theoretical model of the research in Figure 4:

Figure 4. Theoretical model of the research – Organisation of core categories and sub-categories.

4.6. Method discussion

4.6.1. Limitations of the study

By using the chosen ethnographic approach and research methods, I have gained a cross-section of individual and collective accounts of learning and meaning from a diverse sample of healthcare professionals. To gain awareness of my position in the data collection and analysis, I kept a research diary. In my research diary, I reflected upon my interactions within and experiences of the research process. For example, I reflected upon the early mistake of allowing the initial sample to be chosen by the head nurse in the MiMiC practice instead of selecting the participants myself from the very beginning of the data collection (see section 4.4.1.1). I learned that I should have emphasised to the head nurse more clearly in advance the cruciality of basing the recruitment on participation rather than, e.g. professional profile (job title, senior position etc.) or availability.

The change of sampling strategy that followed improved the richness of the interview accounts significantly because I could ask the interviewees about situations where I had seen them displaying agency. Yet, I was mindful of the risk of bias in this kind of a purposive sampling strategy, when I recruited the interviewees and group discussion participants based on my observations of their engagement in the music session.

Upon reflection, I came to see that there were three aspects supporting my choice of purposive sampling. First, I had no prior insight into the planning of the work rotas, meaning which nurses were assigned to work during the time of the music projects. So, the bias of sampling was minimised by these pre-existing and unrelated staffing decisions. Second, I aimed to include as many nurses as possible in the research per music project by scheduling the group discussions and interviews with the head nurse, so that most of the nurses who had been present at work during the music sessions could participate in the research. Third, both the very nature of participatory music practices (see section 3.2.5) and the formulation of my research questions (see section 4.1.3) build upon the premise of *social agency* in the musical processes. Thus, interviewing participants with little to no agency in the music sessions would have been irrelevant for the aims of the research.

In the context of Music and Dementia, the risk of bias was much less significant, since the number of the pre-recruited caregivers taking part in the music project was small. So, I could include most of them in my research. Reflecting on my learning, biases and assumptions during the research process helped me become aware of my relationship with the social context that I was studying, and eventually strengthen the methodological rigour of the study. Still, some limitations of the data collection remained in both contexts.

4.6.1.1. Limitations of episodic interviews

MIMIC

As the data collection was limited to the working hours of the healthcare professionals, most of the participants whom I interviewed were in their *professional habitus* and wearing their hospital uniforms. Subsequently, some of the interviews had a 'reporting' mode, as the answers were expressed quickly and efficiently. I recognised this kind of verbal exchange

from the observed interactions between the nurses during the music sessions. So, it seemed likely to me that the interviews reflected the culture of professional communication in the wards. Since it was not possible to conduct interviews at any other time than during work hours, I have taken this factor into account as a limitation of the study.

MUSIC AND DEMENTIA

The caregivers often had a brief style of narration much like the nurses. Yet, in the nursing home care context, the participants' narrative accounts were more significantly varied with respect to their reflective depth. Furthermore, unlike the nurses, the caregivers had more flexibility in the interviewing hours. Yet, they preferred to be interviewed in their workplace during or immediately after their work shifts, because many of the female caregivers had children. I respected their preferences as I aimed to have as little interference in their lives as possible. In some rare occasions, added researcher flexibility and fast decision-making were needed, when the participants' availability for an interview could change suddenly. In one situation in a nursing home, I had to change my episodic interviewing plan into a group discussion set-up onsite, because the two interviewees were unexpectedly unable to stay for the pre-organised interviews. Nonetheless, the collective accounts in this 'impromptu' group discussion seemed insightful and as such, I considered them as 'rich data'.

4.6.1.2. Limitations of group discussions

MIMIC

When it comes to the group discussions in the context of the MiMiC practice, the nurses reflected upon their experiences of the music projects often for the first time collectively and in-depth. The novelty of this kind of collective reflection meant that the group discussion questions seemed to serve as a tool for the shared meaning-making on such aspects that the healthcare professionals had not thought about before. In addition, some questions needed to be repeated in different ways during the discussion to spark joint reflection. It seemed that the unfamiliarity of open-ended collective reflection may have limited some nurses' preparedness to negotiate meaning.

MUSIC AND DEMENTIA

The group discussions tended to be slightly longer in the Music and Dementia context than in the hospital. The reason for this may be that they took place right after the collective reflection among the musicians and the caregivers that structurally followed the Music and Dementia sessions. This way, the research participants were already 'warmed-up' for the group discussions. Also, the settings of the group discussions in the nursing homes were often a bit less formal than in the hospital, which may have supported the participants' openness to reflect freely on their experiences. On the other hand, it was clearly challenging for the caregivers to reflect upon the meaning of the music practices for their learning and occupational well-being instead of focusing on the perspective of the residents. I considered persistent probing as helpful for facilitating a deeper level of reflection.

4.6.1.3. Limitations of participant observation

MIMIC

As already mentioned, participant observation in the hospital context was, at times, limited by situational factors (e.g. the unpredictability of the situations onsite or the occasionally limited access to patients' rooms). Furthermore, on particularly hectic days at the wards, it was challenging to capture the nurses' interactions and responses during the music sessions as their observable agency could be minimal due to the situational workload. This contextual limitation could not be overcome by making adjustments to the participant observation strategy, as the situational factors were unforeseeable and dependent on the circumstances of each passing moment.

MUSIC AND DEMENTIA

There were no significant limiting factors of participant observation in the Music and Dementia practice, where I could follow each session in close proximity to the interactions. However, it must be acknowledged that it was not possible to register every detail of the interactions during the music session in hand-written fieldnotes. A more detailed documentation would have required video registration, which was not an option due to ethical reasons. All in all, the observation reports based on fieldnotes were successful in contextualising the caregivers' narrative accounts and served, thus, the triangulation of the data.

4.6.2. Reflexive remarks and methodological evaluation

Upon methodological evaluation, I believe it was beneficial for the quality of the research data to hold the episodic interviews and group discussions close to the projects in terms of setting and time. This way, because participants could easily recall their experiences of the musical situations, their narrations mostly unveiled their feelings, learning processes and meaning-making of their experiences.

It was interesting to notice how the interview questions facilitated the reflective meaning-making. It was especially apparent in the reflections of those participants, who would tell during the interview situation that they had not previously thought about the topic at hand, but when being asked, they had opinions and feelings about it. These kinds of new insights during the interviews and group discussions supported the understanding of the suitability and relevance of the questions I was asking, as well as the rigour of the methodological choice of narrative data collection.

In retrospect, however, it may have been beneficial to try out additional means of stimulation in the episodic interviews and group discussions. For example, the use of audio recordings of the music-making or pictures of the musicians in particular situations may have served as a stimulus for recall and narration, especially in situations where the interviewees found the narration of their experiences challenging.

Participant observation has significantly helped to link the interview and group discussion data to the artistic processes and the social situations in the music sessions.

Although this research does not involve participant observation with a focus on artistic creation, having participated in both practices (MiMiC and Music and Dementia) as a musician helped me to ask questions about the person-centred processes of the music-making. My musical knowledge and involvement in the researched practices, thus, helped me to gain a processual understanding of the music-making and the frameworks of social interaction within the music sessions. Such understanding was, therefore, helpful for interpreting the research participants' reflections on the processes of person-centred music-making.

Spending more time onsite outside music sessions may have brought upon additional insights into the short-term legacy of the music practices. Such added approached of data collection, however, would have required permission from the heads of wards and managers of the nursing homes, which was not possible for this research.

During brief moments of the analytical process, I experienced some of the interviewees' difficulty of detailing the significance of their meaningful musical experiences as a challenge for formulating my interpretations. Then, I was reminded of Charmaz' (2006) notion: "However, respondents may not be so forth-coming nor may major processes be so obvious. Even if they are, it usually takes considerable work to discover the subtlety and complexity of respondents' intentions and actions. The research may have entered the implicit world of meaning, but not of explicit words" (p. 34). This notion helped me to search for deeper conceptual bases for the reconstruction of the data.

Primarily, this research aims to tell a *story that matters* (see Alvesson & Sköldberg, 2018, p. 366). Additionally, in line with its pragmatist positioning, it aims to have such practical and instrumental value (see *technological value* in Alvesson & Sköldberg, ibid., p. 367) that can guide future action of practitioners both in healthcare and music.

4.7. Ethical discussion

The ethical principles of this research build upon four categories (see Kvale, 1997; Murphy and Dingwall, 2007). First, the researcher should not cause harm to the participants *(non-maleficence)* and second, the research should take the welfare of the participants as a goal of the study *(beneficence)*. Third, the participants' values and decisions must be respected in the research (*autonomy)*, and fourth, all participants should be treated equally (*justice)*.

In this research, I have assured the participants of complete confidentiality. I have explained the aims and purpose of the research in all situations before data collection and answered the participants' questions about the research. Additionally, I have asked for written informed consent from all group discussion and interview participants and valued their participation in the research *(justice*). The informed consent form acts to secure the participants' rights to anonymity and confidentiality. Also, I have respected the participants' *autonomy* with sensitivity towards their working life demands. Therefore, I have tried to interfere with the participants' professional lives as minimally as possible.

The approval for participant observations was given by the heads/managers of the care units and indirectly from family members of the residents in the nursing homes. As the research took place in the two healthcare contexts, where the majority of people receiving care were vulnerable elderly people, I exercised a particular contextual sensitivity in the

participant observation descriptions and handling of patient information. No personal or recognisable information of any participants of the music session in either context (people with dementia, surgical patients) have been disclosed *(non-maleficence)*.

The research aims to bring about new findings that can improve the working culture and well-being in the workplace of healthcare professionals *(beneficence)*. When the early findings of the empirical study on the MiMiC practice were presented on December 8th, 2017[81], I consulted the participants who were present at the symposium to hear their thoughts on my interpretations and whether they accurately reflected their experiences. I considered the participants as experts of their professional knowledge, and therefore, I approached the research as non-judgementally and openly as possible.

Regarding researcher integrity, I aimed to portray the participants as respectfully as possible, and also, I have interpreted their statements as truthfully as I have been able to (based on the triangulation of the data). Furthermore, the conclusions of this research are originally based on the empirical data, and the translations from Dutch to English have either been made or double-checked by a native-speaking, university degree holding colleague of mine. All pre-existing source material has been transparently referenced back to the list of references and quoted appropriately. These actions follow the guidelines of academic integrity of the University of Music and Performing Arts Vienna (2015; 2017) which call for the truthfulness, originality and independence of good research practice.

Lastly, I have formally written and signed a data management plan of Hanze University of Applied Sciences Groningen, which covers the *codes of conduct*[82] of the Dutch Universities of Applied Sciences (HBO) (see Baljé, Eggink and Klein, 2015). They are in line with the principles of the European Code of Conduct for Research Integrity (ALLEA, 2017) that call for reliability, honesty, respect and accountability of good research practice. These codes of conduct also require safe storage of the research data, which I have committed to by using the personal OneDrive-account provided to me by Hanze University of Applied Sciences Groningen, as well as an encrypted external backup hard drive.

81 On December 8th, 2017, Meaningful Music in Health Care (MiMiC) symposium was held at the Prince Claus Conservatoire of Hanze University of Applied Sciences Groningen. The new practice, training module components, the joint research outcomes as well as early findings of three PhD studies (including this very research) of the PhD fellows were presented. After the symposium, I had the opportunity to member check the early findings with participating healthcare professionals of the UMCG.

82 The codes of conduct cover (a) the societal and professional relevance of the research, (b) respectfulness and availability towards research participants, research funder and research communities through an open-access research output, (c) accuracy and sensitivity of the research design, research question and copyright, (d) integrity, and (e) responsibility for the research progress and costs of the study (Baljé et al., 2015).

5. ANALYSIS AND FINDINGS

5.1. Participation: A necessity for the accumulation of experiences

Participation in the music sessions appears to be essential for fostering healthcare professionals' experiential learning processes within the music practices. Without agency and engagement in the musical situations, new experiential insights into and through the music-making seem to have little ground to grow upon, as was clear in the first round of sampling in the MiMiC practice (see section 4.4.1.1). For example, activity leader Jane reflected upon the importance of taking part in the Music and Dementia sessions first-hand:

> *I noticed… that I think: 'Yes, you can talk about it as much as you want but actually, you have to experience it'. […] You know? And now I have done it twice, and I think: 'Oh yes, so this is what is expected of us!' You can explain a lot about [the music practice] but eventually, you have to experience what it is.*

In Jane's account, the pragmatic view of agency is emphasised. In line with Dewey (1916/2009) and Emirbayer & Mische (1998) Jane's reflection shows how her agency in the music sessions simultaneously orients her responses to, reflections on and anticipations of the music practice. Through agency in and reflective meaning-making of the new musical situations, the healthcare professionals may furthermore experience a shift in their attitude towards the music practices. For example, doctor-in-training Caroline reflects in an interview on the MiMiC practice:

> *Yes, it really is something where you need to be present to really understand it…to see that it really has an impact. And I think indeed: 'As long as you have not seen it, it is very difficult to get the picture of what it is.'*

Caroline's reflection is in line with Dewey's (1938/2015) notion that the value of an experience "can be judged only on the ground of what it moves toward and into" (p. 38). Furthermore, Caroline's account reflects Chadder's (2019) findings of the importance of healthcare professionals' observation in music sessions for increasing their awareness of the music practices (p. 6, see section 3.2.5).

In line with the relativist pragmatist epistemology, which considers learning as a cumulative process of experiencing through agency in situated social interactions and the negotiated meaning-making thereof, participation is the first core category of my research. In this chapter, participation is used as an umbrella concept to interpret the social processes that foster the healthcare professionals' experiences of the music practices and potential acknowledgements of learning benefits. Yet, there are several factors that seem to impact and, at times, limit the healthcare professionals' participation in both participatory music practices, Music and Dementia and MiMiC. These factors are contextual, namely the situation at work and adequate support for participation (see section 5.1.1.), whereas others are connected to the participants' individual and personal ways of relating to the music practices (see section 5.1.2).

5.1.1. Situation at work: contextual conditions of participation

5.1.1.1. Time pressure and staffing levels

MIMIC

The vast majority of participants in this research described their everyday working life as hectic and, at times, stressful. In their narrations, two interrelated situational limitations for their participation in the music practices stood out. These were *time pressure* and *staffing levels*, which were especially notable in the narrations of the hospital nurses in the MiMiC practice. Coordinating nurse Julia explained in an interview:

> *You really are busy the whole day, and I think that it is typical for nurses to want to do everything really well and do everything for the patient that is within their possibilities.*

The tension between the motivation to give excellent person-centred care and the restrictions to do so due to the lack of time is implied in Julia's account. Lack of time is known to create negative emotions in the workplace and, eventually, even pose a risk of burnout (see Lases, 2017). Nurse Lena articulated in an interview:

> *You just have to get things done during the day and sometimes you don't manage to do that, as for example today. That is annoying then, and can be stressful, but on the other hand, you must be able to let it go […].*

Lena's account stresses further how the situation at work creates restrictions for the daily care delivery. Healthcare professionals in hospitals are known to work under intensive circumstances, which can limit their ability to give the kind of person-centred care they are deeply motivated to give (see also Youngson, 2012; Lases, 2017).

Subsequently, these restrictions appear to limit the nurses' time to participate in the MiMiC sessions, as well. The MiMiC practice takes place primarily on the nurses' work floor *while* they are at work. Therefore, the time pressure and possible insufficient staffing levels can directly inhibit their participation in the music session and create disengagement from the music practice. Coordinating nurse Werner confirms this in Smilde et al. (2019)[83]: "*[Disengagement from the music sessions] has to do with the work pressure.*" When the work pressure is too high, it simply may not be possible to participate in the music session. Even with careful planning of a MiMiC project to optimally fit into the daily structures of the hospital wards, the situation at work seems to remain as a major limiting factor for the healthcare professionals' engagement in the music sessions. Reconstructed from the fieldnotes:

> The musicians begin a French-inspired improvisation. By the door next to the mediator a new volunteer worker peeks into the room, stays and listens from where he stands. Soon after him, in the midst of her work duties, nurse Merel joins the music-making mid-piece and walks into the

83 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 98).

> room to sit by the windowsill next to Mrs. de Vries. Merel is smiling and observing the patients' reactions to the music. Shortly, a male nurse comes by the doorway, as well, and stays for a moment to listen. Suddenly, Mr. Jansen's monitor starts beeping and Merel hurries to turn it off. As she is about to take her seat on the windowsill and continue listening to the music, the male nurse by the door signals her to leave the room with him. Duty calls.

As described above, the hectic work situations can change the healthcare professionals' availability to participate in the MiMiC project at any moment during the music session. The more severe events, naturally, are the occurrences of care emergencies. Reconstructed from the fieldnotes:

> [The musicians and the mediator] wait in the hallway because there are two doctors inside the room with a male patient preparing him for discharge from the hospital later in the afternoon. Therefore, the musicians decide to first visit another patient's room and come back after the doctors are ready. The musicians move towards the neighbouring room. Unexpectedly, their preparation of the musical visit that is just about to begin is suddenly interrupted when a large group of nurses dash into a close-by room. An alarm sound is beeping franticly until it quickly stops. Soon after, one by one, the nurses return to the hallway calmly, some returning to their patients in other rooms. This time, the emergency is quickly over.

As an interconnected factor of time pressure, the nurses' participation in the music sessions depends on the staffing levels of the care unit. When briefed about the staffing situation at the ward each day, the MiMiC musicians try to adjust their musical approaches in a way that aims to support the nurses during a hectic and understaffed workday (see Smilde et al., 2019). As a way of reaching out to the nurses, who may not have time to join the musical visits in the patient rooms at all, the musicians bring the music into the nurses' breakroom, where it is offered 'just for them' during their break from work. Reconstructed from the fieldnotes:

> The musicians are told in the morning brief that it is going to be a hectic and understaffed day. So, the nurses are '*really feeling that pressure today*', the coordinating nurse says. Knowing this, the musicians want to bring a piece of energy for the nurses without taking much time of their well-earned coffee break. The musicians approach the breakroom and ask for a permission to enter. Then they tell the nurses that they had just heard how busy the workday is and that they would like to energise the nurses a bit through music. The musicians start a piece by Coldplay titled *Viva la Vida*; 'long live life'. After the piece, the all-female group of nurses comment together that the piece is indeed energising. One of the nurses thanks the musicians for the music that will surely '*get them going*' now, she adds.

These invited musical moments in the nurses' breakroom seem to help the musicians to engage with the nurses, despite the circumstances on the work floor. It seems that these encounters can, furthermore, strengthen the nurses' sense of agency in musical processes. For example, nurse Eva (MiMiC) reflects in Smilde et al. (2019)[84]:

84 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 113).

> *Also, for us, in the coffee rooms, just a private concert. We could, ourselves, tell what we would like to hear, and I found it to bring a nice atmosphere in the ward.*

The shared musical moments between the nurses and the musicians can, thus, be viewed as nurturing the feeling of inclusion in the music-making processes, which is reinforcing the values of participatory music-making (see section 3.2.5).

MUSIC AND DEMENTIA

Similarly, in the long-term nursing home care context of the Music and Dementia practice, the caregivers participating in the three observed music projects experienced time pressure at work. Caregiver Anna described:

> *It does differ, but [the work] it is rather busy, you know? And also, demanding. […] So, yes, there is always something that you can or have to do.*

'Being busy' appears to be a typical working mode for the research participants in both care contexts, which aligns with the notion of the "hurried 'task-list' care systems" of contemporary healthcare (see Youngson, 2012, p. 9). Yet, there are significant contextual and structural differences between how the music practices Music and Dementia and MiMiC are carried out in the participants' workplaces. Subsequently, these differences seem to reveal distinct contextual limitations for the healthcare professionals' participation.

Unlike the MiMiC practice, the Music and Dementia sessions take place outside the caregivers' work floor. The sessions are organised in a separate activity room during a dedicated one-hour time slot. After the sessions, the caregivers also take part in a reflection session with the musicians (see Smilde et al., 2014, p. 254). Hence, the planning of the eight-week-long music project depends on finding the optimal time for the caregivers to be able to take part in the project on a weekly basis without causing interference with their work. Caregiver Mathilde confirms this in an interview:

> *The time [of the music session] of course depends on [the day structure of the ward].*

In the earlier research on the Music and Dementia practice, Smilde et al. (2014) reported that it is necessary to ensure the caregivers' involvement in the eight weeks of workshops and debrief reflections through careful project planning. In my research, however, the caregivers' participation was not consistent throughout the projects. Care coordinator Maria explained:

> *It is a luxury to have the same people participating [in the project] each time, and that is not happening now. It is a great luxury to get to participate in the [music] session for a whole hour.*

When the planning of the project had not been optimised, the caregivers may have initially felt that their participation in the music project added to their *job demands* (see Bakker & Demerouti, 2014 in section 3.3.3.5) during particularly hectic workdays. Activity leader Jane reflected in an interview:

I think sometimes like: 'Oh, you know [...] this is really a beautiful project, Music and Dementia. Yet, it is actually not a very handy time to start [the project]' [...] And I find [the project] tremendously enjoyable, but you know, that is it; [making time to participate in it] is stressful sometimes.

Furthermore, the interview accounts of this research reveal that the caregivers who were recruited to a Music and Dementia project were easily affected by the time pressure of the day-to-day care at the beginning of the music project. Therefore, it seems that the Music and Dementia projects' planning should consider caregivers' resources to participate, rather than their availability per rota alone. It appears that without careful planning, the Music and Dementia projects could run the risk of either stretching the already strained resources of the caregivers or missing the crucial *continuum* (see Dewey, 1938/2015 in section 3.1.2) of their weekly participation in the music sessions. Those participants who took part in the music sessions on their days off work did not bring up feelings of pressure to participate, which further highlights the situation at work as a major limitation for the caregivers' participation in the music project.

Moreover, on understaffed days in the nursing homes, caregivers who took part in the Music and Dementia circle appeared to experience discomfort and even a sense of guilt over being away from the ward for a full hour. Some caregivers seemed to struggle with justifying their participation in the music project due to the insufficient staffing at the ward. Caregiver Wilma described in an interview:

I come from [the ward], I have to hurry as I want to get everything done, obviously... because after the music session, I don't have time to do anything anymore. [...] Then I sit here, and I think like...the first time I thought something like: 'Now I sit here comfortably with the music while [my colleagues] are running around [at the ward]'. 'That there are hardly any personnel. That it is busy! And then, here I sit!' Then I just felt a bit like: 'My goodness, this cannot be! I just sit here, and they have to go on working.'

It appears that the participants' conflicting feelings of responsibility towards colleagues who were not involved in the music project could hinder their own participation in the music session and prevent them from fully engaging with it. Similar observations have been made in expert accounts from the forestudy on Music for Life (see section 2.1.1).

These feelings of discomfort are likely connected to the caregivers' strong professional identities that are linked to values of teamwork and collegial support (see also Ten Hoeve, 2018), as well as to empathy that is triggered by the affective imagining of 'the other's' experiences (see Ricard, 2013 in section 3.3.3.1). The unease related to participation due to concern towards one's colleagues is only expressed in the context of the Music and Dementia practice. The reason for this is likely because in the MiMiC practice, the healthcare professionals are able to decide autonomously at any moment when to step in and out of the music session during their work shifts according to their circumstances at work.

It can be argued that the healthcare professionals' initial resources to participate in the music sessions in both music practices are limited by the *job demands* that the situation at work presents (see Bakker & Demerouti, 2014 in section 3.3.3.5). However, the limitations seem to manifest differently in the two contexts. In the MiMiC practice, time pressure could

physically limit the nurses' participation and keep them away from the music-making, whereas in the Music and Dementia practice, time pressure impacted some of the caregivers' engagement in the music-making and ability to disengage from the work floor duties.

5.1.1.2. Support for participation

Due to the existing contextual and situational job demands, support for the healthcare professionals' participation in the music sessions seems crucial in both care contexts. Two key aspects of the support can be identified in the analysis of this research: first, *being sufficiently informed* about and prepared for what to expect of the music projects, and second, *encouragement for participation* by colleagues in the workplace.

5.1.1.2.1. Being sufficiently informed

Without previous experience of the music project and a framework of what to expect, healthcare professionals in both practices typically experienced uncertainty at the beginning of the music projects. Not knowing what one's own role would be in the project seemed to be a significant cause of hesitation (see also Dewey, 1916/2009 in section 3.1.4). Adequate information prior to the start of the music project was, therefore, particularly important for facilitating the healthcare professionals' participation.

MUSIC AND DEMENTIA

When it comes to the Music and Dementia practice, the analysis suggests that there was a significant difference in the reflections of those caregivers who felt that they had been sufficiently informed about the project and those who did not. The feeling of having been insufficiently informed about the project could cause deep uncertainty for the caregivers. Caregiver Theresa explained:

> *Yes, we were actually thrown into the deep end. […] Naturally the first time was absolutely special. It was also difficult. I already pointed out that I did not really know exactly what was expected from us.*

Not understanding one's own role in the project, particularly, could cause significant insecurity among the caregivers in Music and Dementia. Not only was sufficient information crucial for one's confidence to take part in the project, but also for the understanding of the *purpose* of the project. In all three observed Music and Dementia projects, some interviewed caregivers explained that they were asked to join the project by their managers merely based on their working schedules, rather than a personal affinity for music or motivations for professional development. Theresa continued:

> *Then [the manager] says suddenly: 'Oh yes, a project will start, and it is on Mondays.' Then, it went on like: 'You work mostly on Mondays; do you want to be there? I think it will be something for you.' I did not know what it was. I said: 'Sounds good to me.' […] Instead of receiving information like: 'What do we want to achieve with this and how are we going to*

continue when it is no longer there?' After today [the musicians] no longer return. What do we do with it then? It would be a pity to leave it behind and continue [working] like we always have.

In the previous research on the Music and Dementia practice, Smilde et al. (2014) suggest the following process of briefing protocol for caregivers prior to the start of a project: "During the selection meeting, care staff are briefed about the project and the project team. […] Usually staff become aware of the project and its potential through briefings in staff meetings, usually conveyed by the setting manager […] and through discussion with their team leaders" (p. 254). The accounts in this PhD research imply that the principles of preparing caregivers for the project's aims, as detailed in Smilde et al. (2014), do not appear to be reinforced fully in the observed projects, which had consequences for the caregivers' participation in the music-making.

MIMIC

Contrary to Music and Dementia, the hospital nurses' initial doubt about the MiMiC practice tended to manifest as scepticism about the appropriateness of live music in the ward. This initial concern was prominent in the interview accounts despite briefs about the music practice by the head nurse and the musician team (see also Smilde et al., 2019). Similar scepticism has been previously reported by Chadder (2019) on the attitudes of hospital staff towards live music interventions. In the MiMiC practice, the scepticism appeared to be paired with worry over the music being disruptive to the everyday work on the ward. Nurse Helen shared:

Well, I thought: 'maybe it is not such a good time slot', because in the mornings we are rather busy with all kinds of the things and then, a lot is happening already.'

The initial fear over the disruptiveness of the music practice was furthermore accompanied by the worry over the suitability of instruments being played on the ward. Nurse Helen continued:

Indeed, and perhaps I thought first, like: 'Well, then we will have a whole trumpet fanfare here on the ward before you know it', but that was not the case at all, no.

The suitability of the music practice is a relevant concern, because live music practices are not routinely carried out in the medical hospital environment. Thus, the nurses are likely not exposed[85] to them, as previously argued by Chadder (2019).

When it comes to the 'not-knowing' at the beginning of a music project, Dewey (1916/2009) argues that doubt belongs to the process of experiencing, because the tension between what is already known and what can only be imagined can cause the person

85 In September 2016, the research group Lifelong Learning in Music and the researchers of the UMCG organised a four-day introduction to the MiMiC practice for the medical healthcare professionals of the surgical wards. The introduction included a lecture on the neurological basis on music and well-being, musical demonstrations and in-depth presentations of the MiMiC research design.

uncertainty. Thus, hesitation is an essential part of the meaning-making of new experiences.

In the MiMiC practice, however, the need for the healthcare professionals to be sufficiently informed about the music practice extended to their capacity to support and encourage their patients to join the music sessions. Nutrition assistant Ava described:

> *So, then you can tell the patients a little bit like: 'Well, soon there will be music' and then, they say: 'Oh, it is not for me'. And then we say: 'Well, they might play something else, too'. You know? Then you can prepare the patients a bit, too.*

5.1.1.2.2. Encouragement for participation

MIMIC

In line with Dewey's (1938/2015) principle of the continuity of experiencing, participation in the MiMiC practice appeared to be easier for those nurses who already had experienced it than for those who were new to it. Nutrition assistant Ava explained: *"I think it is easier for us now that we have experienced it once already."* Here, the future-oriented view of learning (see Dewey, 1916/2009; Elkjaer, 2009) is relevant, as Ava simultaneously looked back on her previous experiences of the MiMiC practice and anticipated her participation in future project to be easier. However, for nurses who were still unfamiliar with the MiMiC practice, encouragement to join in and observe the music-making from those colleagues who were further in their process of familiarisation was crucial.

Collegial encouragement for participation was needed especially when a nurse's agency in the MiMiC sessions was inhibited by her/his scepticism towards the music practice. Coordinating nurse Gina explained in Smilde et al. (2019, p. 97)[86]:

> *There are those who completely keep their distance and are happy when the music is over. Then, I will go and talk to them, because I try to emphasise how important it is for the patients, and that one also sees a real effect. Then they go along with it.*

Similarly, in another interview, coordinating nurse Jessica detailed in Smilde et al. (2019, p. 96)[87]:

> *One of my colleagues…was like: 'Do we have to do this? I just like peace and quiet. I never listen to the radio at home.' She just wasn't up for it. And then I tried to explain: 'It's meant as a distraction for the patients. Wound care. Yes, whatever. If they say it works.' And then, she joins me one morning to the music session, and I say: 'Walk along with me, go and have a listen.' And afterwards, she says: 'My goodness, it really breaks the day. The atmosphere at the ward really changes, because suddenly you hear music everywhere. People talk more among themselves; the patients have more energy and it's a distraction when they have their wounds tended to. Less pain.' She saw that it makes sense. I don't have the impression that there are anymore*

86 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 97).

87 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 96).

colleagues who think that this is totally useless, that this is nonsense. No, that is totally gone. The sceptics have been included. Just purely by seeing it.

These kinds of negotiations of meaning are typical in a *community of practice*, where meaning is collectively constructed between the *old-timers* and *newcomers* (see Lave & Wenger, 1991 in section 3.2.2). In the context of the MiMiC practice, nurses who were already acquainted with the music practice and who comfortably participated in the music sessions could be considered as taking the role of old-timers. Their views of the music practice and its benefits for the patients tended to be outstandingly supportive. Consequently, they often worked as 'ambassadors' of the MiMiC musicians to encourage the newcomers to join in from the periphery of the music-making and observe the music sessions closely. These negotiations of meaning between the old-timers and newcomers could help the newcomers to overcome their initial apprehension about the music practice.

In the framework of a 'community of practice' (ibid.), it is fitting to consider Gina and Jessica as 'ambassadors' and old-timers, who attempted to facilitate the sceptical newcomers to move from legitimate peripheral participation towards full participation. Jessica's last account: "*The sceptics have been included. Just purely by seeing it*" is a powerful support for the interpretation of a slowly emerging community of practice within the music sessions that is nurtured by the inclusive processes of collegial encouragement. Also, Jessica's account highlights the significance of *full participation* (see Lave & Wenger, 1991 in section 3.2.2) for the nurses' *situated learning* (ibid.) in the context of the music sessions.

MUSIC AND DEMENTIA

In the Music and Dementia sessions, the caregivers physically engaged in the music-making in 'the circle' by playing instruments and assisting the residents in making music (see section 2.3.2). Furthermore, they were personally acknowledged and welcomed as participants in the music-making by the workshop leader (see *Welcome song* in Smilde et al., 2014, p. 60). The analysis of this study suggests that in the Music and Dementia practice, encouragement was crucial for *daring* to participate in the circle, where the music-making happened. Being asked to make music in the circle was not only perhaps perceived as daunting because the caregivers were invited to do so with professional musicians, but also, because they were asked to step out of their comfort zone: their familiar mode of caregiving. Goffman (1959/1990) explains that stepping into a new role in an unfamiliar social situation is likely to cause insecurity, because one must rely on limited hints and cues of others in order to know how to act (see section 3.2.4).

In the Music and Dementia practice, the caregivers were given a new and unfamiliar role as music-makers, and so, they relied on each other's collegial support for positive reassurance of their 'performance' (ibid.) in the musical situation. For example, in one observed situation, the collegial encouragement seemed vital for caregiver Rebecca, who was unsure about her participation in the Music and Dementia circle with a particular resident, Mr. Haakma. Reconstructed from the fieldnotes:

> In the middle of the second music session of the project, during the first round of the passing instruments activity, cellist and workshop leader Roy offers an African seed rattle to Mr. Haakma.

Mr. Haakma has aphasia, but he tries intensively to communicate through different kinds of sounds and by pointing at people and objects. He tends to shout very loudly when he wants attention, also in the previous music session, which has been experienced as disruptive by the caregivers and the other residents in the circle.

Mr. Haakma takes the instrument and with stable movements, he shakes the rattle; clearly showing his intention of the steadiness of the beat. While playing, he gives a cheeky 'thumbs up' to Rebecca, a young female caregiver sitting next to him. Rebecca smiles back in approval. All three musicians, cellist Roy, harpist Magdalena and clarinettist Sara are playing with Mr. Haakma, who seems to nearly conduct the musicians with the way he moves the seed rattle in large, clear and confident movements. Mr. Haakma is looking at Rebecca for approval and she nods and smiles back at him. As he eventually appears to find it difficult to end the piece alone, Rebecca helps him to bring the piece to an end by slowing the pulse of the playing until it stops.

Then it is Rebecca's turn to play. She holds the instrument and lets it hang in the air. With her left hand she touches it gently from the bottom side. She makes crisp, sprinkled sounds with it. The musicians gently accompany the delicate little sprinkled sounds. It becomes a calm piece and Mr. Haakma observes Rebecca closely by his side. Once more, in the end of the piece, Mr. Haakma gives Rebecca a 'thumbs up' for encouragement.

At the beginning of the fifth session, Mr. Haakma is agitated, and when searching for contact, he slaps Rebecca on her bum. Rebecca tells him to calm down, and he listens and sits down on his seat. He stays alert and begins to engage with the music-making during the framing piece; conducting with his hands in the air and applauding.

After the welcome song, Roy approaches Mr. Haakma with a sound bar xylophone. Mr. Haakma takes both sticks in his hands, corrects his posture and starts playing a stable rhythm: *taa–taa–taa–taa* with two hands. He has a lot of command in his playing and great rhythmical precision. He experiments on playing with one stick against the body of the sound bar and the other one on the centre. When the musicians all join him as accompaniment, he begins to conduct them with the sticks in the air and shows Magdalena and Sara when to play louder. He seems in control over the piece and appears not wanting to end it. As he continues, he brings the sticks close to Roy and Rebecca's heads as to defiantly threaten to hit them with the sticks. He does not touch their heads, though, as Rebecca gives him a firm yet warm look to respect their boundaries. Roy thanks Mr. Haakma for his music as a signal to calm down, and Mr. Haakma agrees that it is time to end the piece. He hands the sticks back to Roy.

In the group discussion after the fifth session, caregivers Eleanor, Rebecca and Sophie discussed Mr. Haakma's participation and disruptive behaviours in the music sessions. Rebecca seemed unsure if her way of supporting him was actually helpful for him to focus on the music-making and to calm down. She, then, revisited the discomfort of his uninvited physical contact. From the group discussion transcription:

Eleanor: *I found it very good how you did it. You restricted [the behaviour] but you did not...*

Rebecca: *[Restricting] works the best with him; then it also stops.*

Eleanor: *Yes, I just thought that you did it very well and I wanted to tell you that.*

Sophie: *Yes, it was really important that you sat there. Someone else might think: 'Phew, there he goes again', but I thought you restricted [his behaviour] positively.*

Eleanor: *Yes, yes. So, I think it is important that someone like you sits next to [Mr. Haakma] because [his behaviour] is unsettling for the group, but you do not spoil his enjoyment. Also, for yourself, it is nice that you can have a positive interaction with him. The slap on your bum is of course unpleasant, but [being there by him] is still better for the whole [group]. You can be pleased that he had a pleasant morning too, because usually he receives so much negativity as he provokes it. He is rejected often, and I think that it is nice for him that you did that so well [with him].*

Rebecca: *Well, yes, thank you. He thinks music is also very enjoyable, so it is nice to see how he responds to it.*

In the exchange above, the collegial support for participation is tangible. As an outcome, Eleanor and Sophie seem to convince the insecure Rebecca of the value of her agency in the music sessions with Mr. Haakma. The encouragement appears to help Rebecca to stop questioning her actions in the circle and to feel acknowledged by her colleagues. Together, Eleanor, Sophie and Rebecca make the value of the caregivers' participation explicit in a situation that could otherwise be unsettled by Mr. Haakma's unpredictable behaviour.

Furthermore, the collegial support helps Rebecca to feel that the attributes of her interactions in the circle with Mr. Haakma are validated and supported by her colleagues. Here, another quality of a community of practice is highlighted. According to Wenger, McDermott and Snyder (2002), a community of practice "is a group of people who interact, learn together, build relationships, and in the process develop a sense of belonging and mutual commitment" (p. 34). Learning in a community of practice requires an atmosphere of openness (ibid., p. 37). In the negotiation of meaning (ibid.) of Eleanor, Sophie and Rebecca, there is a strong sense of openness about the uncomfortable situations with Mr. Haakma, as well as mutual commitment to collegial encouragement. Such support can be viewed as an essential factor of social well-being and flourishing at work as suggested by Seligman (2011) (see section 3.3.3).

5.1.2. Individual and personal factors of participation

5.1.2.1. Attitude, curiosity, openness and motivation

MIMIC

There were inevitable individual differences in how the nurses related to the music practices. As explained, some displayed a sceptical attitude, whereas others showed openness and a curiosity from the beginning. It was typical that the nurses' curiosity was sparked by their interest in what kind of an impact the music-making could have on their patients. For example, nurse Alexandra explained:

> *I was curious whether everyone would like it, all patients. Because, well, I can imagine that if you are sick you do not feel like it at all. But it was beyond [my] expectations; I think almost everyone who participated also had a lot of fun […].*

The concept of co-participation seems relevant here as it emphasises the individual's "conceptions, agency, intentionality, energy and interest in participating and learning through the workplace" (Billett, 2007, p. 62, see section 3.2.1). Moreover, some of the nurses showed special interest in the outcome measurements of the patients' self-reported pain perception in the MiMiC research project (see Smilde et al., 2019, pp. 6-9). In such accounts, the weight of the medical evidence on the benefits of the music-making was significant for increasing the nurses' openness towards the music practice. This finding appears to differ from Chadder's (2019) suggestion that a firmly medical view on live music is likely to work as a limiting factor of the medical professionals' stance towards music practices in hospitals (p. 5).

MUSIC AND DEMENTIA

Like the MiMiC practice, nursing home caregivers were typically curious about the residents' responses to the music. For example, activity leader Jane reflected:

> *With some people, you expect them to enjoy it very much because you actually know that they love music. And for other people, you really think, well: 'I am really curious about [how they respond].'*

Unlike the nurses' accounts, the caregivers' initial curiosity towards the Music and Dementia practice was often connected to a motivation for professional development and learning new ways to use music in the everyday care. For example, caregiver Loes reflected:

> *I wanted to be involved in [the project], it seemed wonderful to me. I have worked in this field for years, but this has never been done before. I thought: 'Now, we are going to do this.' […] Yes, it was completely new for me and I thought: 'I have done this work for almost 30 years, but I have never experienced this.' So, well, I thought it was good to be there [in the project]. Also, to get a bit of a deepening for my profession but also, to interact with the residents once in another way than how I always do.*

The explicit articulation of a strong motivation for professional development through participation in the music sessions is a pronounced difference between the accounts in the two care contexts. In Loes' account on her motivation for participating in the music project, Dewey's (1938/2015) notion of the *purposefulness* of experiencing is clear, as Loes has actively selected the music project as a *relevant stimulus* (ibid.) to respond to in order to develop her professional knowhow. Furthermore, Loes' willingness to participate in the music project for the sake of her professional development emphasises *motivation* as an integral force for a person's growing membership in a community of practice (see also Lave & Wenger, 1991, p. 122).

The healthcare professionals in both care contexts expressed openness and motivation towards finding new ideas for developing the care. Usually, for nursing home caregivers, this motivation was connected to enhancing one's care delivery, as articulated by Loes

above. In the hospital context, however, the openness towards the MiMiC practice seemed connected to a motivation to provide a new complementary service for patients. Nurse Lena formulated in Smilde et al. (2019, p. 112)[88]: "*I find it very nice that we are always trying to improve the care and to be able to do something meaningful for the patients.*"

COMPARATIVE INTERPRETATIONS

It seems that, although most participants shared a motivation to enhance care with the support of live music, the initial positioning of oneself in the process of enhancing care was different between the two care contexts. For caregivers, like Loes above, the enhancement seemed strongly connected to deepening one's craft with the new insights emerging from the Music and Dementia projects. For nurses, like Lena above, the MiMiC projects appeared to offer a valuable new approach for improving care without a further consideration of one's agency in it.

This difference may be explained by contextual differences, as the patient contact is very different in short- and long-term care. The nursing home caregivers work with the same residents for long periods, and thus the need to enrich the daily care delivery seems reasonable (see also Kitwood, 1997). Nurses are known to aim for improving the *patient experience*, meaning the perceived quality of the provided care (see Ryan et al., 2014), mainly during shorter intake periods. In both contexts, however, aiming to use the music practices for answering the *situational needs* of a specific context aligns with the pragmatic notion of learning in this research (see Väkevä & Westerlund, 2009, p. 99 in section 3.1.7).

5.1.2.2. Personal relationship with and preference of music

The healthcare professionals' motivation and openness to participate in the music sessions seemed furthermore related to their personal relationship with music. Most of the research participants in both care contexts articulated that music had personal importance in their lives. Many of them mentioned, for example, past instrumental lessons, choir singing, going to concerts and daily music listening as their musical habits and experiences. Among the research participants in both care contexts, some also preferred to listen to music on the radio during working hours.

MUSIC AND DEMENTIA

The caregivers to whom music was an integral part of the everyday life tended to have a more open attitude towards the Music and Dementia practice at the beginning of a project than those to whom music had less personal significance. For example, caregiver Mathilde voiced:

> *I cannot get through the day without music. If I am at work, I put the radio on immediately. And I just notice that I see now in the sessions how much music touches the residents. Then, I really want to do more [with music at work].*

88 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 112).

Here, Mathilde's enjoyment of music listening seems to connect to her wish to facilitate meaningful musical experiences for the residents. Recognising how music affects the residents and being able to relate to it through her own relationship with music appears to spark Mathilde's motivation to employ music further in the care. Such active form of empathy for 'the other' can be interpreted as compassion, which is characterised by 'acts of kindness' (see Ricard, 2013; Gilbert & Choden, 2013; Youngson, 2012 in section 3.3.3.1).

MIMIC

Similarly, in the MiMiC practice, most of the interviewed nurses described music as a part of their personal lives. They, too, connected their personal musical practises to the MiMiC sessions at workplace. For example, nurse Miranda described:

> *Myself, I have played music for a long time, [I played] the piano. I always find it so beautiful […] Especially the atmosphere, the mood, the emotions. And I think, that is lacking here for the patients [in the hospital].*

By reflecting on music as a personal resource for herself, Miranda displays a compassionate stance towards the patients in the clinical environment. Compassion is a "multitextured response to pain, sorrow, and anguish" (Gilbert & Choden, 2013, p. 98) and it includes kindness and generosity (ibid.). In the context of this research, these aspects of compassion are relevant, as nurses and caregivers alike often made the connection between the relaxing impact of music for themselves and the wish to relieve the suffering of the patients with the help of music.

Another factor for the nurses' participation in the MiMiC practice appeared to be their personal music preferences[89]. To make the MiMiC practice accessible to nurses and to reduce their initial scepticism towards the practice, the musicians prepared a broad musical repertoire that they used while approaching nurses and patients. The diverse range of musical options presented in the MiMiC sessions evoked the nurses' engagement and curiosity, helping them move towards full participation (see Wenger, 1998 in section 3.2.2) in the music-making. Coordinating nurse Gina explained in Smilde et al. (2019, p.97)[90]:

> *There are those, especially when it comes to classical music, who take more distance, which I find to be a pity. But [the musicians] play naturally also really beautiful pop songs, and then, [the colleagues] often also pay attention, because they think it is fun like that.*

On the other hand, hearing classical music or classical instruments for the first time at the workplace could spark new interest towards the music project. As caregiver Wilma from the Music and Dementia practice described:

> *Certainly, the instruments that you are not familiar with… Like that bassoon, I did not know it.*

89 The interviewed nurses have a wide spectrum of musical preferences varying from current radio hits, electronic dance music (EDM), heavy metal, Dutch-language pop-music, jazz to classical music.

90 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 97).

Then, I thought: 'I am curious what kind of a sound will come out of it.'

5.1.2.3. Understanding of one's own musicality

Finally, one's understanding of own musicality seemed to be a critical factor for the caregivers' participation in the Music and Dementia practice, where they were expected to contribute musically in the circle with professional musicians and residents. Smilde et al. (2014) described that the Music and Dementia workshops aim to remove any sense of hierarchy between the participants. Yet, the analysis of this PhD dissertation suggests that when participating in the circle, the caregivers may have been confronted by their own understandings of their musical skills and abilities, which could make them doubt the value of their contributions to the sessions. In a group discussion, the insecurity about one's own musical capabilities caused apprehension for the caregivers. From the group discussion transcription:

Wilma: *Well, yes, then it is a bit like: 'What is expected of me?' Look, naturally, I cannot play [a musical instrument], but I wonder: 'Do I need to continue [playing]? If the residents go along, do I need to continue drumming, or not?' That is a bit like… That is not clear. At the beginning, you drum along a little bit, and then you think: 'Yes, do I need to continue?' or do [the residents] think: 'Stop drumming so stupidly because it is our turn now'?"*

Ineke: *I did not know, either.*

Theresa: *The last time [in the circle] I felt that, too. Then, I had that xylophone and I was just doing something [with it]. I thought: 'Well, that sounds like nothing really. Shall we continue?'*

In this fragment, the caregivers' dialogue reveals a problem in the music practice. The problem is social in terms of the seemingly insufficient communication between music practitioners and caregivers in regard to how the caregivers were prepared for the music project. The problem is also closely related to how the caregivers perceived their musical skills. The tension between the caregivers' judgement of their abilities to make music and the expectations of their participation can bring them to distrust their contributions to the sessions. Calling their participation *'drumming stupidly'* and considering it as sounding *'like nothing'* is a testament of that. These findings are in contrast with the values of the Music and Dementia practice as described in Smilde et al. (2014) and expose a problem in the support system for the caregivers taking part in the projects. The negative self-judgements could, nevertheless, be altered. Activity leader Jane opened up about her initial negative idea of her music-making in the circle:

Yes, I am unable to play any instrument, so I am unable to make music. This, however, is not true at all.

Here, Jane challenges her own beliefs about the value of her musical contributions. She is able to see that the music-making in the Music and Dementia practice is not judged by musical skills, as she previously assumed. Her new understanding resonates with Elliott's (2005) praxialist argument that, rather than being an object or a product of an aesthetic value, music is primarily something that people do (p. 39) (see section 3.1.7). In the context of the Music and Dementia practice, an emphasis on the notion of *doing* music rather than *playing* music needs reinforcement to foster the caregivers' confidence to participate in the music sessions.

5.1.3. From disengagement to engagement

5.1.3.1. From professional distance towards self-allowance to participate

In line with Preti & Welch (2012), the analysis of this PhD research suggests that the healthcare professionals tended to consider the music sessions as primarily meant for patients and residents rather than recognising the sessions as intended for the healthcare professionals alike. Consequently, they often intentionally downplayed their agency in the music sessions. In the MiMiC practice, nurse Lena described how she understood her role in the music-making in a patient's room (from Smilde et al., 2019, p. 98)[91]:

> *As small as possible. Keeping an eye on the patient and after that, I have to come back if the emotions are running high. I think that for us, our role is just a little bit a co-enjoyer.*

Similarly, the nursing home caregivers in the Music and Dementia practice recalled distancing themselves from the music-making. Caregiver Cindy explained:

> *Well, I think that I keep myself away from it a bit, because what is important is [the music] for the residents; what they find beautiful […] It is not for me, I can [listen to the music] at home.*"

In the reflections above, the professional distance appears to be coupled with a compassionate motivation to allow the patients and residents to experience meaningful musical interactions, uninterrupted by keeping one's agency "*as small as possible*" and thus, participating from a distance. Therefore, professional distance does not seem to be intended as a detachment from the social relationship, but rather, as a way of giving care. Still, presence, contrary to professional distance, means *being with* someone instead of *doing for* them (see Benner, 1984/2001; Van Heijst, 2005 in section 3.3.3.3). By diminishing one's own presence in the music sessions for the intended benefit of 'the other', and by sticking to a supposed professional *helping role*, a healthcare professional "establishes 'distance' as a part of the 'professional' relationship" (see Benner, 1984/2001, p. 163). Such detachment is contrary to the values of participatory music practices, which emphasise the involvement of all willing and able participants in the music-making (see Lines, 2018 in section 3.2.5).

91 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 98).

In the MiMiC practice, some nurses felt the need to distance themselves into the periphery of the music practice at the beginning of a project. Nurse Aurora described in Smilde et al. (2019, p. 95)[92]:

> *At the beginning I thought something like: 'What is this? What do we have here now?' Suddenly a whole bunch of people came with big instruments in the hallway. It made me take my time to just look from afar at first, like a cat looking from a tree.*

Observing the patients' responses to and engagement with the music-making seemed to effectively help to shift the nurses' detachment from the music project into growing interest of participating in the sessions (as also argued by coordinating nurses Gina and Jessica in section 5.1.1.2.2). Sparking the nurses' interest and motivation to approach the music sessions seemed essential for decreasing professional distance.

When joining in the music-making in patients' rooms, some nurses appeared to struggle with allowing themselves to have musical agency (see also Smilde et al., 2019). For example, a young nurse, Josephine, described a moment where she joined a sing-along of *Hey Jude* by the Beatles in a twin-room with two of her patients. Josephine reflected in Smilde et al. (2019, p. 99)[93]:

> *That was very special. Eventually, it was funny, because first I thought: 'I just look and see how the patients react.' But it was such fun inside the room, so I thought: 'I will join… I find it a bit… I must remain professional, but I think that I must first wait for a bit, and then, when I see that things are going well, I can join [the session].' Just to stay professional with the patient… One must see that one can still give care… I think that if I go along singing a song, then I am in a way keeping the care in the background. For me, the most important thing of the day is the care. If that is going well, then I can also do things 'for myself'. And that the patients feel good in music, then I can think like: 'Okay, then I can join along.' Because then I am giving care for them, and then I can combine the music and the care.*

Josephine's reflection highlights the nurses' need of finding a balance between managing their *professional impression* (see Goffman, 1959/1990) and having the freedom of musical agency beyond the *professional habitus* (ibid.). First, she observes the music-making from afar, which is typical for many nurses who participated in the MiMiC sessions for the first time. Josephine then decides to join the music-making out of personal interest. Yet, becoming too involved with the music seems to pose a risk of overlooking – or appearing to overlook – the care. Therefore, she only allows herself to participate in the sing-along when she is convinced that the patients are enjoying the music and that there are no acute care needs to be met. Subsequently, Josephine allows herself to decrease her professional distance just enough to meet the patients' needs within the music-making: "*combining the*

92 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 95).

93 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 99).

music and the care", she concludes. This last consideration shows that when reflected upon, a balance between a professional on-duty presence and musical engagement can be found in the MiMiC practice. It shows that, upon reflection, the value of giving good care and sharing musical moments with one's patients can be interconnected.

Goffman's (1959/1990) notion of impression management is helpful for explaining the nurses' need for guarding their professional *front* by keeping professional distance in the musical situations. As explained in section 3.2.4, Goffman (ibid.) argues that individuals try to control the impression that they *give off* to other individuals in a social interaction, and that they aim to protect the *common front* of their profession by following a specific professional *etiquette* on how to act (pp. 14, 28, 95). Josephine's reflection seems to emphasise the particular challenge for nurses to convincingly 'perform' the presumed qualities and attributes of the nursing profession in the new musical situations (see also Goffman, 1959/1990). Goffman's (ibid.) notion of the tension between impression management and self-production in social interactions seems fitting to conceptualise the nurses' apprehensiveness to participate in the MiMiC practice beyond their established professional *performance* of nursing. Given the unfamiliarity of the music practice, the nurses appear concerned about keeping their professional front *intact* (after Goffman, 1959/1990 in section 3.2.4) while taking part in the new musical situations.

MUSIC AND DEMENTIA

Unlike the nurses' accounts in the MiMiC practice, caregivers in the Music and Dementia practice seemed to have little concern for the balance between securing one's professional front (see Goffman, 1959/1990) and allowing oneself to participate in the music sessions. Their lack of a need to maintain a strong professional front seemed contextual and related to the long-lasting care relationships between the caregivers and the residents. Caregiver Anna narrated:

> *[Caregivers] know the resident for some time. That is the beauty of the work. In a hospital, there [the patient] stays for a short time. Here, you see someone for a couple of years, as a result of which you also get to know them better.*

Furthermore, caregiver Eleanor reflected upon the informality of the nursing home care relationship in a group discussion:

> *I have always found [professional distance] terrible. […] I understand it in the hospital a bit better really, because there is more patient turnover also, so you build up less of a bond, and then it is perhaps also easier to keep that distance too.*

Eleanor's point-of-view further highlights the person-centredness of care relationships that the long-term care context allows (see also Kitwood, 1997). Maintaining close care relationships with the residents appeared to be a significant part of what made working in the nursing home care satisfying for the caregivers. Professional distance was seen as something which could potentially hurt that closeness, as caregiver Mathilde explained:

That is not why I started to work in the care; only just to dress someone and then leave again. Anyone can do that. I find that no fun at all, and it takes a big part of the job satisfaction away.

Here, the value of person-centred care for the job satisfaction of the caregivers seems clear (see also Van Heijst, 2005; Youngson, 2012; Lases, 2017 in section 1.2). Job satisfaction, in turn, is known to enhance the healthcare professionals' occupational well-being (see Compton & Hoffman, 2013 in section 3.3.3).

Although maintaining professional distance seemed inessential for the interviewed caregivers, they did tend to visibly downplay their participation in the music sessions, and some appeared to struggle with the personal acknowledgements in the music sessions, especially during the *welcome song* (see Smilde et al., 2014 in section 2.3.2). Caregiver Mona explained the uneasiness of being acknowledged in the circle beyond her professional role as a caregiver:

I, myself, have never really been someone to 'be the centre of attention'. [Being in the centre of attention] makes me always feel a bit uncomfortable.

The participatory music sessions seemed to challenge caregivers to allow the attention to be equally on them instead of solely on the residents to whom they were used to focusing on in their daily care. Here, Goffman's (1959/1990) performance-metaphor for social interactions is again applicable: being recognised as a participant in the music-making rather than as a caregiver shifts the attention from the task that is being performed to the qualities of the person who is performing it (see section 3.2.4). This shift often seemed to take the caregivers by surprise and likely caused feelings of uneasiness as described by caregiver Mona above. To overcome the uneasiness, Goffman (1959/1990) argues that a person's "previous repertoire of performances needs to be adjusted to the new setting" (p. 79) for the continuity of self-production in the new situation.

For some caregivers, the challenge of adjusting to the new situation caused apprehension, and thus, they underwent a process of self-allowance to participate in the music sessions. The process of self-allowance was significant for the caregivers' growing agency in the sessions. Activity leader Jane struggled with her process of self-allowance and daring to overcome her fear of participation. As a healthcare professional, who was used to the task-centred culture of care (see also Van Heijst, 2005; Youngson, 2012 in section 1.2), Jane struggled to allow herself to step out from the periphery of the project and step into the circle of music-making. After having observed two sessions of the project outside the circle, she reflected in an interview:

I notice now that I think: 'Oh, I have now observed two times, for me it is really a rather big step to say the next time: 'I will go and sit in the circle,' because I am not a 'circle-person'. […] And when I think: 'Oh no, now I have to be in the circle and then I also get a music instrument from [the workshop leader] in my hands and I have to do something with that. You know? And then I think: 'Yes, of course [this fear] does not make any sense. Because if I just shake it, it is okay, really. That is a difficult thing for me. And I find that, yes, difficult. I sometimes find that difficult. And then, I think: 'Don't be so stupid. Why is it so difficult, really? Just go and sit in the circle and shake that thing!'

What stands out in Jane's reflection are her future-oriented processes of self-assurance and meaning-making: "*Because if I just shake it, it's okay really*" shows that Jane rationalises her own judgements to put her fear of participation into a perspective. Her reasoning is in line with the pragmatic notion of anticipating the consequences of actions and 'thought as an instrument' for problem solving (see Elkjaer, 2009 in section 3.1.1) In response to the new situation, Jane seems to focus on the non-threatening expectations of her musical contributions, as she states that she would just be asked to *"do something with [the instrument]."* Yet, her fear of 'just doing something' is keeping her from participating.

The pragmatic philosophy also emphasises imagination as a crucial component for being able to anticipate the consequences of actions (see Elkjaer, 2009 in section 3.1.1). Imagining herself participating in the circle and anticipating the positive outcome of daring to do so is central to Jane's reflection. Jane continues:

> *The next time, I will try to sit in the circle. […] Yes, and perhaps when I have done it once, then I will think: 'Well, yes, how stupid of me; so strange of me that I have worried myself so much over it.' That I now think: 'Oh, as long as I don't have to sit in the circle.' Instead, I will think: 'Yes, why not, because it is incredibly fun.'*

Again, here the pragmatic notion of the backwards and forward dimensions of learning (see Dewey, 1938/2015 in sections 3.1.2) is fitting to explain Jane's process of self-assurance to participate in the Music and Dementia sessions. Also, the notion of co-participation that recognises agency as a foundation of individuals' engagement in and meaning-making of new experiences seems to be a relevant concept in Jane's personal learning process (see Billett, 2004 in section 3.2.1).

Furthermore, Jane's reflection emphasises the extent to which the music practice can personally challenge the caregivers, as well as the doubt (see Dewey, 1916/2009) that they must overcome in order to take part in the circle. In this kind of an internal conflict that participating in the music practice can evoke, the support of colleagues who are taking the role of old-timers in the community of practice (see also Lave & Wenger, 1991 in section 3.2.2) seems again vital for overcoming the newcomer's struggle. Jane explains:

> *I see that [my colleagues] like it and then afterwards I hear that they are really enthusiastic about [the circle]. And Mathilde said also: 'Well, actually I found being in the circle even nicer than being outside it.' Then it makes me think: 'Yes, maybe I will say that after next week as well.'*

Later, at the end of the music project, Jane revisited her difficulty with participating in the circle during a group discussion with Mathilde. By then, Jane's thoughts about what actually kept her from participating in the circle had developed. From the group discussion transcription:

Q: *What is challenging in it for the caregivers?*

Jane: *To do it.*

Mathilde: *To dare to do it, yes.*

Jane: *To dare.*

Mathilde: *Daring, I think above all.*

Jane: *Yes.*

Q: *Hmmm.*

Jane: *And not to have the thought that you…*

Mathilde: *…that some people are simply not musical and do not have anything to do with music, and then, I think that the step [to participate] becomes even higher.*

Jane: *Yes, but I think… [in a separate staff training it was said] that you don't have to be musical…*

Mathilde: *No.*

Jane: *…to be able to make sound.*

Mathilde: *True, that is absolutely so.*

Jane: *Yes, and that no sound is strange. You know, above all, the daring is the biggest step.*

The awareness that above all, daring is the main challenge for breaking professional distance and moving closer towards full participation in the Music and Dementia practice is a major realisation that has critical implications for how Jane and Mathilde experience the music project. When daring to participate, the caregivers can eventually start making meaning of the new processes that underpin the musical experiences. Here, Dewey's (1916/2009) view on experiential learning seems fitting:

> "To 'learn from experience' is to make a backward and forward connection between what we do to things and what we enjoy or suffer from things in consequence. Under such conditions, doing becomes a trying; an experiment with the world to find out what it is like; the undergoing becomes instruction – discovery of the connection of things" (p. 147).

It can also be understood that the accumulation of experiencing during the weekly Music and Dementia sessions – in or out of the circle – gradually increased the caregivers' ability to engage in the music-making. This interpretation is supported by Dewey's (1938/2015) principal of continuity of experiencing, which can lead to *growth* (ibid., see section 3.1.2), such as the one interpreted from the group discussion data above.

5.1.3.2. A sense of professional responsibility for 'presencing' in the music sessions

The participant observations in both music practices in this research suggest that healthcare professionals tended to be more attentive in the music sessions when observing or co-participating with one's own patient(s) and resident(s). In the nursing home context of the Music and Dementia practice, caregiver Cindy confirmed:

> *Yes, yes. I am specifically focusing on [the group of residents for whom I am responsible], really, but I also look a bit beyond that.*

Previously, in sections 5.1.2.1 and 5.1.4.1 it has been argued that observing the patients' responses to the music-making was especially significant for increasing the nurses' interest and openness towards the music practice, which aligns with the findings of Chadder (2019). In this PhD research, however, it can be further construed that attentiveness was connected to a sense of professional responsibility towards one's patient. For example, nurse Lena explained:

> *Yes, I have occasionally [participated in the music sessions] … When [the music] was for my patient or for a patient that I knew, then yes, now and again, I would just come in and catch a glimpse. […] It touches your patients somehow and you, too, must [be there] to see that.*

Lena's account emphasises the urgency of *being* by the patient's side when s/he is emotionally moved by the music, which supports an understanding that the underlying values of person-centred *presencing care* (after Benner, 1984/2001, p. 57 in section 3.3.3.3) are reinforced through the participatory music sessions. In fact, it appears in Lena's reflection that person-centredness can be nurtured by the emotional opening that is catalysed by the music-making. The person-centred value of responding to one's own patients' emotional needs (see also Youngson, 2012) seems, thus, like a relevant consideration when it comes to the healthcare professionals' participation in the music sessions. It can, therefore, be assumed that the value of *presencing care* (see Benner, 1984/2001) may work as a factor for reducing the nurses' professional distance from the music practice and instead, increase 'presencing' in the musical situations, where the nurses can share emotionally charged moments with their patients.

5.1.4. Communities of practice: a central concept of collaborative participative learning

In the interpretative analysis of this research, the concept of a community of practice (Lave & Wenger, 1991, see section 3.2.2) is central to analysing community members' participative processes in the music practices, as well as to the emergence of a new collaborative fellowship between healthcare professionals and musicians. The concept of communities of practice helps to describe the situated, collaborative learning processes taking place within the music sessions.

MUSIC AND DEMENTIA

In the Music and Dementia practice, for example, sharing new insights into the music-making and the residents' responses to it began to spread beyond the music project to other colleagues and even to the residents' family members. Caregiver Eleanor accounts in an interview:

> *More and more people are saying: 'Hey, we want to have a look, too, once!' So, we try to arrange that a bit, everyone is very curious. […] They hear positive stories, and that, indeed, leads them to want to participate; to come and have a look.*

As explained in section 3.2.2, a community of practice creates a *social fabric of learning* (Wenger et al., 2002, p. 28) that is fostered by the members' willingness and commitment to sharing new ideas and insights with each other. In Eleanor's account above, it seems that sharing insights with other colleagues could elicit their interest in the music practice. Here, the core principle of collaborative learning in a community of practice is fundamental, as the experiences of the music sessions seemed to spread across the work community, and thus, eventually contributed to its development (see later section 5.3 on Learning benefits).

MIMIC

Similar processes of circulating new insights into the MiMiC practice occurred within the community of practice of a hospital ward. The observations suggest that the nurses who were in the *extreme peripherality* (see Wenger, 1998, p. 118) of the music practice could still become included in the learning processes, primarily in two ways: first, through a mediator's daily email detailing each music session (see section 2.3.1.2) and second, by gaining insights into the music sessions through passing conversations with *full participants* (after Lave & Wenger, 1991) and occasional film clips of the music-making posted on the work community's joint WhatsApp-group.

5.1.4.1. Emergence of a community of practice among musicians and healthcare professionals

MUSIC AND DEMENTIA

As previously explained, the caregivers participating in the Music and Dementia practice were faced with insecurity about the expectation of their musical actions in the circle. This insecurity might, furthermore, have been linked to an uncertainty about the rules of the practice in case the rules were not sufficiently spelled out. Activity leader Jane reflected in a group discussion:

> *Last week, there were more people making music and then, there were residents who started applauding. So, the caregivers joined them. Afterwards, it was told that we should not applaud anymore.*

Jane's account demonstrates the importance of the musicians' role in making the rules of practice explicit—something which was needed in order to facilitate *newcomers*' full participation in the music projects.

The emergence of a community of practice requires mutual respect, trust and safety (Wenger et al., 2002). Likewise, the analysis of this research suggests that respect for the caregivers' professional knowhow was vital for establishing trust among the musicians and the caregivers. In the Music and Dementia practice, the caregivers benefitted from being encouraged to use their professional knowhow in the circle to feel professionally valued (see also Music for Life in section 2.1.1). Sometimes, the encouragement was missing in practice. For example, caregiver Alicia explained in a group discussion:

> *[The workshop leader] told that we were not allowed to help [the residents]. Therefore, I have now been a bit more withdrawn. It does not feel good. We know the residents so well.*

Mutual respect of the knowhow and expertise between the professional *teams* (see Goffman, 1959/1990 in section 3.2.4) seems, indeed, a necessity for supporting the caregivers' co-participation in the music sessions (see also in Smilde et al., 2014). Otherwise, the newcomers may remain in the periphery of the practice (see also Lave & Wenger, 1991), as Alicia stated: "*Therefore, I have now been a bit more withdrawn*".

When one's role in and the rules of the practice became clear, the collaboration in the circle could begin to flourish. Caregiver Theresa described in an interview:

> *Now it is really natural. You just take your instrument and you pass it on carefully and encourage [the residents] with a nod, without words. You encourage someone to try and play.*

The statement *"now it is really natural"* emphasises a significant development in the emerging community of practice. In fact, by the end of the three observed Music and Dementia projects, most of the caregivers described a strong sense of collaboration with the musicians. For example, caregiver Eleanor explained in a group discussion:

> *[The musicians] listen to us when we have something to tell them. For example, if we say they could approach something differently, they listen to us and will do it [in that way] the next time, too. It is a very pleasant collaboration.*

The need for recognition and respect for the caregivers' professional knowhow is, once again, noticeable in Eleanor's reflection on the development of the collaborative relationship between the musicians and the caregivers.

MIMIC

Similarly, in the MiMiC practice, establishing mutual trust and respect between the musicians and the nurses could foster the development of an interprofessional collaboration. It seems that, gradually, the nurses started considering the musicians as a resource for providing person-centred care to the patients. In some situations, the nurses began to initiate a musical collaboration for the benefit of a patient. In one observed situation, the

nurses collectively initiated a musical gift for a patient, Mr. Noor on his birthday. From Smilde et al., (2019, pp. 104-105)[94]:

> The nurses have made a request for the musicians to play a piece of Coldplay for Mr. Noor today. It would be a birthday gift for the patient on behalf of the ward, and the ward staff hope that the musicians could keep it a secret until the 'big reveal'. There is a group of nurses gathering on the hallway now. They want to see how their gift will be received.
>
> Mr. Noor is sitting on his bed. He seems to have been busy with his phone before the musicians come in, as he now puts the phone down. The bed has been adjusted in an upright position, and Mr. Noor has his iPad lying next to him on a tray. Unlike the day before, Mr. Noor is alone in the room now. He greets the musicians without hesitation. He re-adjusts his position on the bed as a means to have a direct eye contact with the musicians and to prepare for the music that is about to come.
>
> The musicians gather around in the empty space in the middle of the room facing Mr. Noor. Clarinettist Jonas initiates the interaction with a hint of a suggestion in his voice: '*We have a piece for you…*', and without further ado, the musicians start to play *Viva la Vida*. Mr. Noor looks instantaneously overjoyed. His face turns into a wide smile as he immediately recognises the piece by the first staccato chords of the introduction. He casts a thrilled glimpse towards the nurses who have now gathered at the doorway of his room witnessing the surprise they have arranged for him. Quickly, Mr. Noor reaches for his iPad – still keeping his eyes on the musicians - to record the rest of the piece on video. After the recording starts, he enjoys the music through the lens of his gadget.
>
> The doorway is now full of nurses. They are all smiling. This is *their* gift for Mr. Noor. Mr. Noor sends a few glimpses at them as if to ask: '*Isn't this wonderful?*' After the piece comes to an end, both Mr. Noor and the nurses applaud eagerly and give rich compliments to the musicians.

The initiation of the collaborative action shows the nurses' evolving agency in the music-making. In Emirbayer & Mische's (1998) pragmatic terms, "agency is always agency *towards* something" (p. 1012, see section 3.2.1.). Here, it seems that the nurses' growing agency was moving them towards a recognition of the value of the live music practice as a new kind of a connector between them and their patients. It appears that the nurses' increasing co-participation in the music sessions began to allow more collaboration to emerge between the musicians and the nurses. Subsequently, this collaboration allowed the nurses to display care or small acts of kindness (see also Youngson, 2012 in section 3.3.3.1) and connect with their patients through the new channel of music-making.

In another observed situation, the emerging community of practice seemed to thrive in a particular setting, where the nursing and the music-making were *performed* (see Goffman, 1959/1990) simultaneously. The observation focuses on moments in a twin-room shared by Mr. Smit and Mr. Kleine. From Smilde et al., (2019, pp. 40-41)[95]:

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94 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 104-105).

95 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 40-41).

Mr. Smit is already behind a closed light-yellow curtain while two nurses are putting on plastic gloves. Quickly, they disappear behind the curtain to work on Mr. Smit's wound. The musicians greet Mr. Kleine and gather around him as he is in plain sight on his bed. Flautist Madelief starts to play first some notes on her flute. From behind the curtain, the sounds of the nurses' instructions for Mr. Smit are clearly audible: *'You can lie on your back, sir.'* Madelief begins an improvisation with a repeating motive arising from her first notes. Roy follows. The improvisation is quiet and lingering. In the background, the sounds of wound care blend into the piece.

Mr. Kleine finds the music beautiful. Madelief asks if he would like another piece, and he does. Then, Madelief asks the two wound-tending nurses if Mr. Smit would also like that. *'Yes, he says'*, one of them answers. *'Yes, could you play a waltz by Strauss?'*, Mr. Smit asks now with a strained, yet loud voice. The musicians are surprised by his question, and their excitement is audible: *'A waltz by Strauss? We can certainly do that!'*, Jonas answers eagerly. Madelief agrees. So, *The Blue Danube* begins.

As the piece ends, Mr. Kleine compliments the musicians: '*Wonderful.*' By now, the nurses are finishing the wound care, and they appear from behind the curtain. One of them talks on behalf of Mr. Smit, who is still out of sight: '*Mr. Smit gives you applause.*' Madelief tells him that the musicians are happy to play for them and would like to come back tomorrow if there is a desire for music. The nurses throw their plastic gloves into the trash bin and when leaving the room, they comment: '*This was nice!*'

The following day, the musicians return to Mr. Smit and Mr. Kleine. The curtain is closed again for Mr. Smit's continuing wound care. The musicians go in as they did the day before and greet Mr. Kleine, who is looking healthier. Madelief asks what he would like to hear today. He has a wish: a piece by *Queen*. Roy says: '*We have a piece by Queen!*' And Jonas adds: '*Did you already hear a bit from the hallway?*', as the musicians have just played a Queen song in another room. But Mr. Kleine didn't. Jonas continues: '*The lyrics have symbolism.*' Then, they begin *I want to break free.* Jonas improvises within the song with a rich clarinet solo. *'Grandioso!'*, Mr. Smit shouts with a voice of spontaneous excitement and strength. He is also getting healthier. During the piece the nurses comment: '*I like doing wound care like this.*'

The musical situations in the room of Mr. Smit and Mr. Kleine seem mutually inclusive for the musicians and the nurses; the nurses allow the musicians to work side-by-side to them, but also, while working on the wound care, the nurses take part in the musical interactions. Goffman (1959/1990) writes that when *teams*, such as musicians and nurses, are in contact with each other, their social interaction can be seen as a dialogue in which the definition of the situation is maintained (see section 3.2.4).

In the example of wound care and music-making, the nurses and musicians aimed collaboratively to enhance Mr. Smit's experiences during the unpleasant procedure of the treatment. So, the musicians and the nurses can be understood to have had a *common social framework* of the situation at hand (see Goffman, 1959/1990, 1974). It can furthermore be argued that the musicians and the nurses shared a *common front* (ibid.), as the participation in the music-making and the aims of the care treatment became integrated. For example, when the nurses mediated communication between Mr. Smit and the musicians; "*Mr. Smit gives you applause*", the nurses' agency in the situation went beyond their performance of nursing and wound care. Rather, the newly established social framework (ibid.) created

a new way for the nurses and the musicians to work towards enhancing the patients' well-being as an integrated team. The patients can, then, be seen as the audience for the musicians' and nurses' *team performance* (see also Goffman, 1959/1990).

Allowing the integration of the nurses' and musicians' collaboration to happen appears to have benefits for the nurses and the patients alike. Doctor-in-training Caroline elaborates in Smilde et al. (2019, p. 102)[96]:

> *Well, the curtains were closed of course, but from what I heard is that it was painful for [Mr. Smit], that wound care. The nurses have to clean [the wound] ... But both he as well as the nurses really liked to have that music in the background, because it distracted a bit from what they were doing. [Mr. Smit] could focus on something else for a moment, and it was, thus, also easier for the nurses. Of course, it will still hurt, but that distraction is really very nice.*

Caroline's statement emphasises how the musicians' presence in the wound care not only distracted the patient from his pain, but also helped the nurses to perform the task. In Caroline's account, it is clear that the musicians' inclusion in the care situation could establish a new collaboration that supported the *job resources* (see Bakker & Demerouti, 2014 in section 3.3.3.5) of the nurses involved in the wound care (see later section 5.1.4.1).

This episode of wound care is a meaningful example of an integrated form of the nurses and musicians' interprofessional collaboration, which also supports the claim of an emerging community of practice within the music projects. In line with Wenger (1998, p. 5), the four main elements of learning in a community of practice can be identified in the described episode. First, the broadening horizon of *meaning* (see also Väkevä & Westerlund, 2009) of the collaboration and its influence on job satisfaction, as expressed by the nurses: '*I like doing wound care like this.*' Second, *practice* as a new emerging partnership in the shared *social framework* (see also Goffman, 1959/1990) of improving the patient's experience of care. Third, *community* as the mutual engagement and belonging emerging upon the developing relationship between the nurses and musicians. Fourth, *identity* as becoming a collaborator in the new interprofessional partnership and a *team performance* beyond the established professional performance teams of nurses and musicians (see also Goffman, ibid.).

5.1.4.2. From dwelling to handholding: the many forms of participatory actions

The analysis of this research, primarily with respect to the observation data, provides insights into the healthcare professionals' various ways to take part in the music sessions in both care contexts.

MIMIC

As previously proposed, in the MiMiC practice, the context and setup of the music sessions allowed the nurses to autonomously move closer to and further from the situations of music-making. Legitimate peripheral participation could take the forms of observing the music sessions from afar for a given time – sometimes for as a short peek from the doorway

96 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 102).

into the patient's room – or simply being peripherally on the ward during the session without joining in. In the patients' rooms, nurses often limited their physical participation in the music session to observing by the doorway to the room or sitting away from the centre of the music-making. Yet, *being there* as co-participants allowed them to see their patients' responses to the music-making without fully participating in the situation. Observation data suggests that the participants of the MiMiC practice were able to shift their musical participation back and forth flexibly and rapidly. Reconstructed from the fieldnotes:

> The musicians visit Mr. Smit and Mr. Kleine. As the second piece of their visit, clarinettist Jonas, cellist Roy and flautist Madelief play a French-inspired waltz improvisation with a melodica solo. A specialist nurse, a doctor-in-training and a nurse suddenly appear outside the room by the doorway in the midst of their work. They start dancing to the music together, swinging from side to side, and research nurse Ines signals them to come into the room as an invitation. They take some steps closer to the music-making by the doorway, listen and smile, and still sway their bodies to the swing of the waltz. When the piece is over, the young doctor-in-training comments: '*Nice!*' before they retreat back to their work.

The following day, the musicians visit the two patients again. During another piece, 'The Blue Danube' by Strauss, the same specialist nurse appears again outside the room to the patients. Reconstructed from the fieldnotes:

> A specialist nurse comes by the doorway when the piece of Strauss begins. He starts conducting to the music with one hand, the other one holding his patient files. He moves to the music expressively, catches a smile from his colleagues who are inside the room and then, when he must go, he walks away.

These reconstructed descriptions portray moments of engagement that can emerge spontaneously without set beginnings or endings. Such swift moments are typical for participatory music-making (see Turino, 2008 in section 3.2.5). These moments can be seen as existing in the vertical dimension of time, *Kairos*, which describes the unique quality of the present moment (see Sipiora, 2012). The *kairotic* moments of musical engagement may be meaningful for the development of person-centred care relationships, as Youngson (2012) points out: "Caring doesn't take any time at all, it happens in magical moments. It turns out that investing a little time up front, in the care of the patient, is one of the magical ways of making more time to care" (p. 17). From the small moments of *engagement* (see Seligman, 2011 in section 3.2), the nurses' participation in the music sessions could grow increasingly towards sharing the musical experiences with their patients.

The observed ways of sharing musical moments included actions of giving care and helping, such as (a) documenting the musical pieces for the patient on a smartphone or a tablet when the patient asked for it, (b) adjusting the patient's physical posture in bed for musical engagement, (c) handling beeping machines in the room, or (d) bringing a patient in a wheelchair or in her/his bed to a private room to experience music. The shared engagement could also mean singing along, moving to the music, and verbal and non-verbal encouragement for the patient, such as reassurance for participation, handing tissues to wipe away tears when the patient was emotionally moved, and some physical

touch (e.g. a touch on the shoulder for emotional support).

Furthermore, as a form of displaying care, nurses might begin to initiate musical surprises for their patients and for their colleagues, for example on their birthdays or as a musical wish, as described in the previous section 5.1.4.1. In its most collaborative form, the nurses' co-participation could become integrated with the music-making as described in the case of Mr. Smit's wound care (see section 5.1.4.1).

MUSIC AND DEMENTIA

In the Music and Dementia practice, as already discovered by Smilde et al. (2014), participation can move *in and out* of focus during a music session. Particularly for residents with dementia, this means that one may be highly engaged in the music-making in one instance and drift away further from it in the next, while still 'being there' peripherally (ibid.).

However, the analysis of this very PhD research, which specifically focuses on the agency of the caregivers, suggests that the participation of caregivers observing from outside the circle was considerably different than that of the caregivers participating in the circle. As observers, the caregivers could follow the session in full, yet without proximally engaging in the processes taking place in the circle. The observing caregivers did not typically leave the room until the session was over, which was different compared to the nurses' participation in the MiMiC practice, where the nurses left the musical situation whenever they chose or needed to.

It can be argued that for many caregivers, observing from outside the circle was an important step towards full participation, especially for those who struggled to dare to join in the circle. Observing the session came without the premise of physically taking part in the musical processes. Caregiver Loes reflected:

> *Observing felt a bit safer for me, because…Then, it was my… then I had a task.*

Wenger (1998) notes that observation can offer newcomers a "casual but legitimate access to the practice without subjecting them to the demands of full membership" (p. 117). In line with Wenger (ibid), the analysis of this PhD research suggests that the feeling of safety while observing the music session stemmed likely from the familiarity of observing one's residents, instead of focusing on one's agency in the shared musical action. This interpretation aligns with the findings of the forestudy on Music for Life (see section 2.1.1). For some caregivers, however, who seemed to be further along in their journey towards full participation (see also Lave & Wenger, 1991), observing outside the circle could feel less rewarding, or even disengaging from the music practice. These caregivers seemed to have strongly preferred participating in the circle. Caregiver Anna articulated:

> *Well, I found it the nicest to sit in that circle, because then you can participate, too. And I found the observing also rather nice to do, because then you are really focused… you are looking at everyone. But I liked it the most when I could participate myself, yes.*

Again, Anna's account supports the interpretation that co-participating in the circle could foster a fuller sense of agency than being outside the circle. This view aligns with the pragmatic view of the relationality of agency centring around engagement with the environment (see Emirbayer & Mische, 1998, 3.2.1.). Caregiver Eleanor elaborated further in an interview:

> *[In the circle], you have more interaction with the residents, and that can be verbal [contact] with the person sitting next to you but also eye contact with the others. And that happens easier in the circle than outside of it. […] And I find that nice about the role in the circle: stimulating the people and also being able to nod [back at them]. That I find nice.*

In the circle, the caregivers were seated next to the residents and engaged in the music-making by moving to the music and singing along. The caregivers and the residents may also have been asked to play a percussion instrument or conduct the musicians with a baton. Besides, the caregivers facilitated the music-making by helping the musicians to offer instruments to the residents, pass on instruments along in the circle and hold them out for the residents, when needed. The caregivers may have also been asked to play together with the resident to encourage their music-making (see also Smilde et al., 2014). Furthermore, the caregivers usually encouraged the residents with verbal and non-verbal input.

Similar to the MiMiC practice, the caregivers in the Music and Dementia practice engaged in acts of care, such as bringing residents in and out of the music session room and correcting the residents' seating or wheelchair positions to increase their comfort during participation. The contextual differences between the two practices were, however, particularly visible in the healthcare professionals' strategies for displaying care during the music sessions. The hospital context influenced the nurses' minimal physical contact with their patients and the apparent need to avoid acting 'out of character' (see Goffman, 1959/1990 in section 3.2.4), whereas the context of the nursing home care allowed plentiful physical touch, handholding, moving to the music together, mutual gazing and mirroring of one another. Reconstructed from the fieldnotes:

> It is the fourth session of the project. Janneke, a woman in her seventies with advanced dementia and severe aphasia is accompanied by her caregiver Mona, who sits by the side of her wheelchair. Mona has been giving care to Janneke for years, so she is curious to see how Janneke will respond to the music-making. When workshop-leader Mieke greets Janneke during the *welcome song*, Janneke responds with a smile and laughter.
>
> On the second round of the welcome song, Mona and Janneke gaze tenderly at each other, laughing and smiling while they are welcomed to the session by Mieke. Janneke seems calm and connected to Mona. Calmer than before the session started, at least. During the first round of the passing instruments activity, it is Janneke's turn to play, if she accepts to do so. However, she does not return Mieke's eye contact, when Mieke approaches her. So, instead, to give Janneke a musical gift, viola da gamba player Ivan leans towards her and begins playing a solo piece just for her. Janneke listens quietly while her eyes are intensely looking outside the circle. She listens calmly with an apparent awareness of the piece being made for her. Mona observes her closely, and later in the debrief after the session, tells that she saw Janneke become a bit emotional during the piece.

> During the fifth session, from the beginning of the framing piece onwards, Mona and Janneke are listening together and exchanging warm looks with each other. Their interaction seems to be growing increasingly connected as they share the music with each other.

Later in an interview, Mona reflected upon her participation in the circle with Janneke:

> *You also encourage the residents when they get a musical instrument, so that they will take the lead in the music. You guide them in that a little bit. Yes, Janneke also often takes my hand, so I hold her hand and respond to her emotions.*

It appears that the processes of person-centred music-making described by Mona resonate with the values of person-centred care (see sections 1.2; 3.3.3.3). The nurturing of compassionate contact through music-making is clear in Mona's reflection, and it echos the aims of person-centred improvisations (see section 3.2.5).

5.1.4.3. The fronts and backs of participation: underlying mechanisms of engagement

When analysing and interpreting the observations of the healthcare professionals' participation in the music sessions, there appears to be a clear difference between participating in the presence of the patients or residents, compared to when patients and residents are absent from the social situations.

MIMIC

In the MiMiC practice, in particular, the difference between the nurses' observable musical participation on the work floor and in the privacy of their coffee breakroom was striking. During the music sessions on the ward, the nurses' participation and collaboration with musicians was primarily centred around the patients' experiences of the music-making. In the coffee breakroom, however, the musical interactions often felt less formal. Also, the music-making blended with the nurses' personal life events, such as celebrations of their birthdays.

The coffee breakroom was a space for the nurses to unwind from their hectic work. The musicians visited the space with the nurses' permission. Nurtured by the privacy of the breakroom, dialogical processes began to emerge between the nurses and the musicians. For example, the nurses began to ask the musicians questions about the music-making and about the sessions with the patients in an informal manner. Reconstructed from the fieldnotes:

> The musicians, flautist Madelief, cellist Roy and clarinettist Jonas begin an improvisation for the ward staff with an introduction to a specific moment with a female patient the day before. The piece is meditative, and the cello is in the centre of it. There is a warm earthy atmosphere in the room as a contrast to the clinical environment of the ward. At the end of the piece, someone comments: '*Beautiful!*' and '*Impressive!*' Madelief explains that sometimes the musicians come and play the radio hits; recognisable pieces, but sometimes they try something different, as now. Nurse Merel begins to ask how the musicians know what to play when they improvise

> and do not know what the others are about to play. Merel seems genuinely interested in the processes that underpin improvisation. Madelief answers: *'You don't always know that, and it is exciting for us.*' Merel continues to ask how the improvisations happen with the patients in the rooms. Roy explains the different approaches that the musicians are using, for example asking for a landscape or an emotion or colour. Merel responds: '*I find that special*.' Madelief answers: '*Yesterday it was difficult to do that in a room of four people, because you get many different ideas like from Alaska to a jungle to the sea*.' Merel, who was present in that patient room at the time laughs: '*But that was good fun!*'

In the privacy of their breakroom, nurses can 'take a break' from the performance of their professional role without the fear of being exposed to the patients. Goffman's (1959/1990) notions of impression management (see sections 3.2.4 and 5.1.4.3) seem helpful to conceptualise these observations. Especially, Goffman's (ibid.) metaphors of the *frontstage* and the *backstage* of the (professional) performance are relevant for describing the different ways that the nurses participate in the music sessions with and without patients.

It can be understood that in the musical situations where the patients were present, the nurses' need for maintaining their professional front was accentuated. This interpretation is supported by Goffman's (1959/1990) argument that in the frontstage region of the performance, the audience – in this research, the patients – expects the performer's appearance and manner to be consistent (seealso, section 3.2.4.). According to the observations, the nurses seemed to aim to 'perform nursing' according to these expectations. In the *backstage* region, however, the performers could do things 'privately' apart from the audience (ibid., p. 116). They could choose to 'behave out of character', so, it was necessary to keep the backstage hidden (ibid.).

In this research, the backstage metaphor could be applied to the interpreted social interactions in the nurses' coffee breakroom. There, the nurses' participation with the musicians seemed more relaxed, collegial and informal in comparison to their interactions in the presence of the patients. In one particular situation, in the backstage region of the breakroom, nurse Linda was persuaded by her colleagues to conduct the musicians with a baton during her birthday celebration. From Smilde et al. (2019, p. 100)[97]:

> Roy tells Linda that they have an offer to make for her. '*Oh, God…*', she replies. The room is quiet with the colleagues listening to Roy. While the musicians wait for a conductor's baton to be handed to them by the mediator, Linda makes a realisation: '*Oh, now [the conducting] comes*'. Then, she rushes to offer the musicians a piece of apple cake. The musicians thank her for the kind gesture, but Roy insists: '*Gladly later, but first…*' He does not finish his sentence but instead presents the baton to Linda, while her colleagues are laughing and commenting lightly. '*Oh no*', Linda shouts, but accepts the offer and the colleagues around her begin to enquire with a humoristic tone: '*Ooh, what do you need to do now?*'
>
> Roy asks if Linda knows what the baton is, and she tells him that she does. She laughs and seems apprehensive about what is about to happen. Roy reassures her gently that she only needs to paint in the air and the musicians will follow – that is, if she accepts the offer. Colleagues begin to cheer her on, and as a response, she takes the baton and acknowledges her role with a

97 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 100).

new determination in her voice: *'I am the maestro!'* A male colleague takes her statement further and encourages her jokingly: *'Music, maestro!'* Other colleagues respond with kind laughter, but by now all of them have their eyes on Linda, who is preparing to conduct.

Before she begins, Linda asks if she should conduct all three of the musicians or just one. The musicians explain that she can choose as she likes. *'Oh no!',* she laughs with the previous nervousness returning to her voice. Again, she corrects her posture, stands up straight, smiles and begins her piece with a confident swing of the baton. She is the maestro now. Musicians follow instantly. As she conducts, she is narrating to her colleagues what she is doing. Someone in the corner of the room is filming her in action. Linda's posture becomes increasingly relaxed and she begins to experiment with the baton.

She tries different tempos, wide horizontal movements, fast vertical strokes and always she gets a different set of sounds in return from the musicians. Linda starts to laugh, and her colleagues laugh with her. She has a calm look of enjoyment on her face. Linda ends the piece with a long note with a crescendo in the end. As an immediate response, her colleagues applaud and comment: *'Well now, wonderful, beautiful!'* Linda, who looks relaxed, comments: *'Thank you so much, this was really fun.'* The musicians congratulate her on her birthday and Linda concludes: *'Thank you for the birthday present!'* She laughs again lightly and freely.

This description shows the process of participating in the music-making in the backstage region without the restriction of keeping one's professional performance *intact* (see also Goffman, 1959/1990 in section 3.2.4). Although Linda was in an unfamiliar situation and an unfamiliar role in the musical interaction, she dared to 'act out' of character as a nurse and become a conductor in the hidden backstage region. She was supported by her community of practice, who cheered her on: "*Music, maestro!*"

MUSIC AND DEMENTIA

Using Goffman's (1959/1990) stage metaphors once again, the caregivers' interactions in the circle with the residents and musicians could be seen as frontstage performance, where the caregivers seemed focused on the residents' participation and experiences, as they downplayed their own musical agency (see section 5.1.3.1). The interactions in the backstage region could be seen taking place during the joint reflection moment between the caregivers and the musicians after each music session.

In terms of the interactions in the backstage region, the reflection sessions provided the caregivers a possibility to share their insights into the processes within the music project. The caregivers were encouraged to comment on the processes from their individual perspectives. Caregiver Mona told in an interview:

> *You give each other tips. Naturally you share your experiences [with each other].*

Furthermore, the reflection session as a backstage region seemed to be a place for addressing uncertainties and areas of the project that need growth. Caregiver Theresa reflected:

> *I think that we are still in development. Also, the musicians; they help and advice each other, like: 'What can we do better [in the music sessions]?'*

The openness to collaborative learning described in Theresa's account is a key characteristic of a community of practice (see section 3.2.2). Consequently, it can be argued that, in the absence of the patients and residents as an audience of the healthcare professionals' occupational performance, the backstage region serves as a significant space for the emergence of the communities of practice between the musicians and the healthcare professionals.

5.2. Experience: The fundamental core of new knowing

5.2.1. Principles of continuity and interaction: experiencing leading to new knowing

Experience is the second core category of this research. The data analysis suggests that the healthcare professionals' agency in and meaning-making of the social processes in the music sessions are critical for what kinds of changes and learning processes can take place. For example, caregiver Cindy reflects in an interview on a Music and Dementia project:

> *If I think about the first time [in the circle], there was an uncomfortable atmosphere. As in: 'I don't know what I have to do.' And then, I didn't really engage in it. And the second time, I sat there more relaxed because I knew what would happen. And then [the music] also struck a nerve more.*

Cindy's reflection, as with many other interviewees' accounts, can be interpreted through the perspective of Dewey's (1938/2015) philosophical pragmatism. The main principles of experiencing, continuation and interaction (see section 3.1.2), are prominent in Cindy's account.

In Cindy's reflection, the disagreeableness (see Dewey, 1938/2015, p. 27) of the new experience (i.e., not knowing what to do at the beginning of the music project) leads to disengagement from the music-making. Yet, through the accumulation of experiencing and increased familiarity, the disagreeableness of the previous experience appears to wear off, which facilitates Cindy's growing agency in the circle during the second session.

Furthermore, it can be understood that in Cindy's account, the value of her experiences in the circle is connected to her increased ability to relax and engage with the music sessions as the project progresses. Subsequently, the quality of Cindy's experiences of the music-making intensifies: "*and then [the music] also struck a nerve more.*" Here, Dewey's (ibid.) concept of the value of experiential learning[98] seems relevant. Dewey states that the value of an experience "can be judged only on the ground of what it moves toward and into" (p. 38).

5.2.2. Experiencing through the social self: looking through the eyes of others

In the analysis of the second core category *Experience*, three main developments of experiential processes and experienced changes stand out in the research participants' accounts in both contexts. These are *Environment, Communication and interaction*, and *Emotions*, as previously illustrated in figure 4 (see section 4.5.5.3). In all three sub-categories, the healthcare professionals' reflections on their experiences of the music practices seem tightly intertwined with their perceptions of the patients or residents' musical experiencing. For example, coordinating nurse Julia reflects in an interview:

> *That feeling of having someone's attention just for yourself: 'I lie here in bed, and they are here just to play for me', that is a very special feeling. And that is all that is needed sometimes.*

98 Experiential learning in this research refers the philosophical pragmatist positioning that considers learning as taking place through reflection on 'doing'. Doing includes all the learner's actions, emotions, and thoughts. This research does not refer to later models or theories of experiential learning, such as Kolb (1984).

In her reflection above, Julia is literally narrating from the perspective of the patients to explain what the meaning of the MiMiC practice is for herself as a coordinating nurse. She is actively imagining the patients' experience of receiving a musical visit and attaches value to it from the imagined viewpoint of 'the other'. Two aspects stand out in this kind of interconnectedness of experiencing. First, in Mead's (1934/2015) terms, a person interprets her/his experiences *through the eyes of the other*, as 'the self' is fundamentally social. Mead (ibid.) explains: "We cannot realise ourselves except insofar as we can recognize the other in his relationship to us" (p. 194). Second, there is a strong basis of empathy for the patients in the healthcare professionals' reflections on shared musical experiences.

As explained, empathy manifests in different ways, including *emotional resonance* and *imagining* how the other person is thinking and feeling, and how one would think or feel in their place (see Ricard, 2013 in section 3.3.3.2). Coordinating nurse Julia's interview account clearly exemplifies these two aspects – looking through the eyes of the other and empathy as imagining the perspective of the other – that seem to underline the healthcare professionals' reflected-upon experiences of the music practices.

5.2.3. Environment: experiences of change within the clinical surroundings

5.2.3.1. Experienced changes of workplace atmosphere, mood, and mindfulness

As argued previously, work pressure could prevent nurses from joining the music sessions in the MiMiC practice (see section 5.1.1.1). Yet, it appears that being unable to take part in the music sessions in the patients' rooms did not mean that the music-making could not impact the nurses' experiences of their work environment. For example, the nurses' interview accounts suggest that even in the extreme periphery of the music-making, hearing music could relax the atmosphere of the clinical work environment and accompany the work. Nurse Alexandra described (in Smilde et al., 2019, p. 98)[99]:

> *Well, for myself I noticed… I heard [the musicians] the whole time, also while I was doing other things. I continually heard people play somewhere and it made me quite cheerful while I was working. I was whistling, and other colleagues were whistling along, as well. So, that was quite cosy and relaxed. It did not distract me from my work, but it was there in the background, just creating a relaxed atmosphere.*

The experienced atmospheric changes during the music sessions in the workplace that were repeatedly described in the narrative data align with the findings of Chadder (2019).

Based on the interview accounts, it can be understood that live music served as an *aesthetic change agent* (see DeNora, 2000, pp. 51, 65) that could influence the nurses' personal experiences of their acoustic work environment. Music could, thus, have value for their job satisfaction, as implied by nurse Alexandra above: "*it made me quite cheerful while I was working*" (see also Smilde et al., 2019, p. 98; Turino, 2008).

The experienced atmospheric changes and feelings of improved mood that were catalysed by the music-making could last beyond the music sessions. Most prominently,

99 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 98).

in the reflections of the nursing home caregivers, the calming atmosphere that the music sessions created could carry on from the session itself into the work sphere on the ward. Caregiver Anna articulated:

> *Look, I always came in [from the music session] feeling very happy. Then, sometimes I also started singing at once when I saw a colleague. I said: 'Well, good morning!' You know? Or rather, [I sang]: 'Good afternoon, it is great that you are here!' And then, I got her attention. So, I always left the sessions feeling really joyful.*

Furthermore, the caregivers recognised that their own feelings of relaxation, as brought out through music-making, contributed to the collective sense of calmness on the ward. Caregiver Mona explained:

> *[…] It brings a sense of calmness into the ward and to the living room [of the ward]. It brings that sense of calmness into the living room area because you are no longer running around and hastily doing things. You transfer that feeling to the residents, too. So, I feel we have to just take a step back, although the pressure of the work is really high. But the calmer you are, the calmer the residents become.*

Mona's reflection highlights how centrally the principle of interaction (see again Dewey, 1938/2015 in section 3.1.2) is part of the healthcare professionals' experiencing of the music sessions. In line with Mead (1934/2015, see section 3.2.3), Mona's reflection furthermore underlines the reciprocity of experiencing and meaning-making that happen through the responsive 'social self'.

Another notion that stands out in the data is the healthcare professionals' similar descriptions of feeling anchored in the present moment and perceiving time differently during the music-making. For example, social worker Doris describes (in Smilde et al., 2019, p. 106)[100]:

> *It also brings you back into the moment. And maybe by being in the moment, you go out of the autopilot mode of simply continuing with what you were doing. [Live music] works in a reviving way. Look, people in the hospital…often have the music on and are often not very actively listening to it in the background. But with the musicians, you are actively listening, and then, you are in the 'here and now'.*

Doris' description of being brought into an active and present state of the 'here and now' through music-making resonates with the concept of *mindfulness.* One of the goals of mindfulness is to bring individuals into a state where they are fully present in their actions (see also Langer, 1989; Compton & Hoffman, 2013 in section 3.3.3.3).

What is striking in Doris' account is how live music seems to have changed the work experience from feeling like one is on 'autopilot', a task-centred habitual work mode, to a state of active listening. Here, Turino's (2008) notion of music *awakening people from habit* (see section 3.1.6) is fitting. Also, in terms of mindfulness, Langer (1989) explains that

100 I have used this data in the previous research on the MiMiC practice in which I took part (Smilde et al., 2019, p. 106).

when anchored into the moment, a person can gain sensitivity to the context of her/his experiences, which is clear in Doris' reflection. Interpreting Doris' account as a description of a moment of mindfulness through engagement with music is supported by the findings of Lecuona and Rodriquez-Carvajal (2014) suggesting that listening to music can induce a state of mindfulness and create relaxation, positive emotionality, and self-awareness in the present moment (p. 6, see section 3.3.4.2).

Furthermore, when interpreting Doris' description of the MiMiC sessions in the framework of mindfulness, her view on the music working in a "*reviving way*" seems to connect with Langer's (1989) concept of mindfulness and well-being: fostering the ability to connect with one's environment and creating new ways to think about one's experiences (see section 3.3.3.3), which aligns with Seligman's (2011) PERMA model of well-being (see section 3.3.2).

The challenge of connecting mindfully with one's work environment and the people in it seems, in the context of this research, to be connected to the constant sense of a lack of time. Therefore, *taking time* seems crucial for gaining a feeling of mindful calmness, concentration and connectedness. Coordinating nurse Jessica tells in Smilde et al. (2019, p. 98)[101]:

> *These are really quite wonderful pieces, to listen to just for a moment. Like: 'What is the patient experiencing now?' And for yourself, it's a moment of peace, as well. A moment where you stop, like: 'Okay, we're doing something completely different from the usual things of the day.'*

It seems that the healthcare professionals' connectedness to the present moment through music-making may increase their job satisfaction mainly in three different ways: improved relaxation and calmness, increased concentration, and becoming energised by the music. In the MiMiC practice, a nurse described that the music-making offered "*a moment of calmness and just being in one place, so that you just get away from your thoughts*" (from Smilde et al., 2019, pp. 106-107)[102]. Similarly, in the Music and Dementia practice, the caregivers reflected nearly unanimously on the calming effects of being in the present moment in the music sessions. Many called the sensation of the mindful calmness as 'Zen', although they seemed unable to explain what the 'Zen' was. Caregiver Theresa described:

> *It is truly a moment, when you are simply only there for the resident who sits next to you. [...] It is very special; you cannot explain it. Then, you tell the colleagues back on the ward: 'Yes, it feels very strange, it feels like a total 'Zen'.' But you cannot put it into words, it is a feeling. The residents also feel [the Zen].*

Here, Theresa appears to be describing experiential knowing beyond words. Dewey (1938/2015) makes the distinction between *knowing how* (expertise) or *knowing that* (beliefs, emotions etc.). In Theresa's reflection, she describes 'knowing that' the music sessions created an indescribable sensation of a mindful presence, 'Zen', although she does not

101 I have used this data in the previous research on the MiMiC practice in which I took part (Smilde et al., 2019, p. 98).

102 I have used this data in the previous research on the MiMiC practice in which I took part (Smilde et al., 2019, pp. 106-107).

'know how' it happened.

The catalysed experience of 'Zen' through live music was also frequently mentioned in the forestudy on Musique et Santé, where Bouazouzi explained: "*[The nurses] become more 'Zen', calmer and de-stressed*" (see section 2.1.2). Similarly, caregiver Wilma detailed in an interview that for her, the peaceful experience of 'Zen' was something she felt both physically and mentally:

> *I notice it in myself, when I'm stressed, I am restless in my body. That's the same for [the residents], probably. So, it's actually a very nice moment just to listen to the music. You're back to being yourself when you get calm.*

In the healthcare professionals' reflections, it can be interpreted that the music practices created moments of mindful presence; connecting and reconnecting with the environment and with oneself. In line with DeNora & Ansdell (2014), it can be argued that the music sessions could accumulate *moments of flourishing* (p. 9) by enhancing the healthcare professionals' mindful connectedness and creating atmospheric changes in the work environment. Ansdell & DeNora's (2012) notion of the reciprocal connectivity of flourishing (see section 3.3.2) seems clear in the participants' accounts in this study; flourishing in relation to each other.

When it comes to experiences of concentration brought on by live music in the workplace, nurse Simon explained in an interview that feeling focused and connected during a MiMiC session helped him to gain a better overview of the work tasks. Simon described in Smilde et al. (2019, p. 107)[103]: "*Then you can put everything in order: 'this must be done first, then that, then that.'*"

Finally, in terms of becoming energised by the music-making, social worker Doris emphasised the need for finding time to be present in the music sessions even during a hectic workday. Doris argued in Smilde et al. (2019, p. 107)[104]:

> *I think that in terms of getting energised, quite frankly, it is much more important for me to stop for a moment, again to 'be in the here and now'. These are also moments where you re-charge your batteries, because if you get out of the 'merry-go-round' here - which the hospital is - and literally stop to listen to something that is beautiful, then you fill up [with energy].*

Doris' statement aligns with Youngson's (2012) call to action to be present in order to improve one's care delivery: "It's a paradox: if you don't have enough time to care, slow down, stop rushing, and pay more attention" (p. 17). Doris' reflection again highlights the potential of participatory live music practices for creating moments of mindful connectivity by catalysing experienced changes in the clinical work environment and in one's mood.

103 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p.107).

104 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p.107).

5.2.3.2. Experience of transportation through musical imagining

In addition to the healthcare professionals' experienced changes of the atmosphere in their work environment, as well as their mood and mindfulness, the nurses and caregivers also described a feeling of 'transportation' through the music. The concept of transportation from the clinical environment was mentioned in the interviews and group discussions in both music practices. For example, caregiver Mona reflected:

> *Well, the last time I really experienced 'Zen', I was tired, and when I sat there listening [to the music], my thoughts wandered off completely with the music.*

Being transported from the hectic working life for a moment by the live music can be viewed as a resource for combatting exhaustion. For example, DeNora (2000) explains that music, as an aesthetic change agent, can create a *virtual realm* that allows an individual to experience her/his physical surroundings differently (pp. 60, 66, see section 3.1.6). It can be essential when the tension between the individual's needs and her/his experienced external demands are high (ibid.). As such, music provides resources for reflexive subjectivity (ibid). In line with DeNora's (2000) reasoning, Mona's account above suggests that person-centred music-making can create a virtual realm of 'Zen' within the clinical environment of her workplace.

Similarly, in the MiMiC practice, during an improvised piece of music for a patient, nurse Lena experienced the transportation of her workplace into an ocean with whales through musical engagement and imagining. From Smilde et al. (2019, pp. 109-110)[105]:

> The musicians enter a room where a woman is laying in her bed. The musicians begin with an improvisation that the woman […] asked to be joyful. The piece sounds much like ethereal world music and as the musicians play, the woman's feet move to the beat of the improvisation. Nurse Lena, who is the patient's caregiver, stands by the doorway listening and observing. The patient films the musicians to capture the piece. In the end of it, she describes: '*I could hear the sea and a whale swimming by.*'
>
> On the following day, the musicians begin an improvisation about whales for the woman. Underwater music. The woman follows closely, and nurse Lena observes by the door again. At the end of the piece, the woman thanks the musicians; she heard the whales again.

Later in an interview, Lena looked back on the situations in her patient's room where the whale-improvisation took place. Lena reflected in Smilde et al. (2019, p. 110)[106]: "*Like that whale-piece that was made, where you hear very clearly that there is a whale swimming to the surface. It is really strange to hear that, but it makes you think: "Gosh, what do I hear here, actually?*" As Lena recounted the image of whales surfacing in the ocean, she seemed to describe a strange new experience of the transformation of her work environment, which happened through musical imagining of the improvisation. It seems that the music-making may

105 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 109-110).

106 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 110).

have fostered subjectivity (see also DeNora, 2000 in section 3.1.6), as it stimulated Lena's imaginative capacity to experience the transformation of the hospital ward into an ocean. In Turino's (2008) terms, the potential of music to evoke imaginative experiences and associative connections can be seen as an artistic resource for gaining a "temporary sense of a life more deeply lived" (p. 18). The pragmatic view of learning recognises imagining as a fundamental process of experiencing (see Russell, 1998 in section 3.1.6).

The interpreted experiences of transportation through musical engagement were also reflected upon the perspectives of patients and residents. For example, in the MiMiC practice coordinating nurse Jessica recalled another moment in the room of two men, Mr. Smit and Mr. Kleine. From Smilde et al. (2019, pp. 42-43)[107]:

> On the last day of the music project, nurse Amanda stands in the room of Mr. Smit and Mr. Kleine, when the musicians walk in. Both men are lying in their beds, ready for the music. 'Good morning' greetings go around, and as the musicians enter the room, Amanda finds a seat facing the two men directly in between their beds. She sits on an armchair, her back against the wall, holding a folder with patient files on her lap.
>
> Flautist Madelief opens the conversation. '*Well, this is our last day*', she says. '*We have visited you every day*', she continues. '*It has been a pleasure for us*', she says on behalf of the trio. She goes on to recall what has happened during the music sessions and counts the different improvisations that have been made. She introduces a new idea now: '*Since there are the three of you in the room; the nurse is here, too… What is your name?*', she asks the nurse. '*Amanda*', the nurse answers. Madelief repeats her name as a confirmation, and then continues her new proposal: '*We have made improvisations for them [pointing at the men], but it would be nice to also receive some input from you*' *[looking at Amanda*]. Amanda nods.
>
> Madelief then asks her for input and offers a suggestion as a starting point of the piece: '*It can also be something that you, for example, wish for these men, something that we can give through the music.*' Amanda has an answer ready. She says that she wishes both of them relaxation, because of the tough time they have had: '*Mr. Smit especially is very tense, and Mr. Kleine has lost a lot of energy, so I would like some music that makes them relaxed.*' […]
>
> Cellist Roy compliments Amanda on her idea and soon a relaxing improvisation begins. Mr. Smit coughs at the beginning but quiets down soon after. The musicians are not disturbed by the coughing, as it had been previously explained to them as a sign of relaxation by the medical professionals. Madelief and Roy play a soothing duet. Clarinettist Jonas joins in with long notes on the clarinet. Like the day before, Mr. Kleine looks at Mr. Smit to see if he is enjoying the music, and when Roy finishes the piece with low pizzicati, Mr. Kleine reacts by looking at him and smiling in acknowledgement. The men applaud softly. Roy asks Amanda if this was what she had in mind. Amanda answers: '*Yes! It was a very relaxing piece.*' […]
>
> Amanda remains sitting on her chair in between the men when the musicians begin their final piece, a song that the men would likely have heard on the radio, a Robbie Williams song. Amanda holds on to her folders on her lap, sitting quietly and concentrated on the men, who seem moved by the music. '*Beautiful, very good*', she compliments the musicians before it is their time to say goodbye. '*This was good for us*', Mr. Kleine concludes.

107 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 42-43).

Later, in an interview, coordinating nurse Jessica reflected in Smilde et al. (2019, p. 43)[108]:

> *You are in bed, you are ill, and the music starts […] In the sense of improvisations, I think that everything else simply disappears into the background. I think that the patients feel it that way, as well, and I thought that was really wonderful to see. Like the two gentlemen. The last day the, curtain was open. Those men were transported. Full of attention. They were not in that bed anymore. That was really wonderful to see.*

Again, Jessica's account describes a moment that links to three of the main concepts of experiencing in this research. First, following Seligman's (2011) PERMA model and the concept of musical flourishing (see also Hesmondhalgh, 2013; DeNora & Ansdell, 2014 in section 3.3.4.2), Jessica appears to interpret the patients' experience as one of flourishing through their engagement in the music-making; being elevated beyond their sick-beds and experiences of physical illness. Here, the notion of Kairos is once again relevant (see Sipiora, 2002; Hermsen, 2015; Rusi-Pyykönen, 2020 in section 3.3.3.3). Through the *kairotic* moment of the musical engagement, the circumstances for flourishing could be created and valued. In Jessica's reflection "*They were not in that bed anymore. That was really wonderful to see*" (Smilde et al., 2019, p. 43), Jessica seems to narrate the kairotic potential of the musical improvisations and their value for supporting the well-being of the patients, which is pivotal for the nurses.

Furthermore, Jessica's reflection links again back to the core concept of mindfulness as she describes: "*Those men were transported. Full of attention*" (ibid., p. 43). Being attentively present in the moment with an acceptance of what is happening is in the essence of mindfulness (Gilbert & Choden, 2013). When interpreting Jessica's take on the musical situation with nurse Amanda, Mr. Smit and Mr. Kleine, Gilbert & Choden's (ibid.) notion of mindfulness as a tool for becoming anchored in the present moment and furthermore, becoming a "keen observer" (p. 136) of that moment seems fitting. Mr. Smit and Mr. Kleine, according to Jessica's account, are brought to a mindfully present and attentive state through the improvisation, through which they can be distanced from the discomfort of the hospitalisation.

Finally, the distancing from the hospital environment through musical experiencing seems again fitting to DeNora's (2000) concept of *virtual realms* (p. 56). The interpreted feelings of transportation that music-making can generate seem, then, connected to the *aesthetic technology* of self-production (ibid., p. 7). It can be seen that person-centred music-making is a powerful force for creating spaces for mental transportation and imagining for both healthcare professionals and patients. Jessica's previous account, "*In the sense of improvisations, I think that everything else simply disappears into the background*" (in Smilde et al., 2019)[109] underscores this claim.

It is noteworthy that the described experiences of transportation – both from the perspective of the healthcare professionals, e.g. Lena's reflection upon the whale-improvisation, and the patients' point-of-view, e.g. Jessica's interpretation of Mr. Smit and

108 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 43).

109 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 43).

Mr. Kleine's experiences – are connected to the creation of person-centred improvisations, rather than performances of rehearsed pieces. Similarly, the caregivers' described experiences of 'Zen' link primarily to improvised music in the moment, as person-centred improvisation is the sole musical approach used in the Music and Dementia practice. Based on healthcare professionals' accounts, it seems possible that the dialogical processes of person-centred improvisations, which focus on creating musical interaction in the kairotic dimensions of the present moment, seem particularly relevant for catalysing mindful connectivity in the care environment. This, in turn, may foster moments of flourishing.

5.2.4. Communication and interaction: experienced changes on social connectivity

The second question of this research is: "*What resources and social changes can music sessions generate for the nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?*" Therefore, it seemed relevant to observe and ask the research participants about how the live music practices impacted their communication and interactions at work. Four elements emerged through the data analysis: *experienced decrease of professional hierarchy, catalysis of communication and interaction, development of care relationships*, and *perceived kindness and personal recognition*.

5.2.4.1. Experiencing a decrease of professional hierarchy

MIMIC

The analysis of the participant observation data of this research suggested that nurses and doctors tended to have different kinds of contact with the patients during the music sessions. Unlike nurses, who often shared the music with the patients, doctors tended to have very little visible agency in the music sessions (see also Preti, 2009).

The nurses and doctors of the surgical wards had separate breakrooms. Subsequently, the participant observation of this PhD research captured very few moments of music-making in the nurses' coffee breakroom where doctors were present. However, occasionally, the doctors who were visiting patients decided to stay and observe the music sessions for a short moment. Reconstructed from the fieldnotes:

> The musicians play a jazz standard, *Autumn Leaves* outside a room with a female patient in contact isolation. Flautist Madelief first listens to cellist Roy and clarinettist Jonas, who are playing the melody and a walking bassline of the familiar tune. Later, she joins to improvise a solo on the piece with her flute. Nurses Leila, Helen and research-nurse Ines are listening in the hallway nearby.
>
> Suddenly, a doctor exits a neighbouring room with a colleague. His attention is caught by the musicians and he starts to move to the music. He is now dancing in the hallway, and soon, his physician colleague joins him in the hallway dance. Both of them really seem to enjoy the music; dancing and tapping their feet onto the shiny vinyl floor of the ward. Their momentarily playfulness makes the observing nurses chuckle lightly. Shortly after, the doctors throw a smile at the musicians as they pass them by before continuing their round. Roy nods back at them with a smile.

Passing moments such as the one described above had meaning for the interviewed nurses. Coordinating nurse Jessica reflected that the music sessions could bring out new sides of their colleagues, which helped to bridge the hierarchical gaps between doctors and nurses, as well. Jessica reflected in Smilde et al. (2019, p. 104)[110]:

> *As the week went on it became much more serious and more and more [colleagues] came in to listen. Also, the support staff like physiotherapy or the doctors walked past and asked, 'What's going on here?' That's also why it became a little bit more relaxed. A little looser. Freer.*

By evoking curiosity and engagement, the music sessions appeared to catalyse a decrease of the gap between the different professionals. Coordinating nurse Gina confirmed:

> *And you do notice that [the hierarchy] disappears, then. That is really nice, absolutely.*

What appeared to be helpful for the blurring of hierarchical lines between the nurses and the doctors was shared experiencing of the participatory music sessions. Nurse Frederik explained:

> *Certainly, yes. You are just all equal, you are doing it together. And I think that is what the music does; you become aware of each other's vulnerable sides because everyone joins in.*

In Frederik's reflection, the values of inclusion and equality of participatory music seem clearly emphasised (see also Turino, 2008; Lines, 2018; Matarasso, 2019 in section 3.2.5). Furthermore, in Goffman's (1959/1990) terms, it can be again proposed that the music-making loosened the nurses' and doctors' professional fronts momentarily, which may have reinforced a new collegial feeling within the community of practice. For example, physiotherapist Reinder narrated:

> *[…] they say that music connects people. Music can change certain relationships, yes; fraternise them. All 'Menschen' became 'Brüder.' That is how it is.*[111]

In addition, the doctors' increased curiosity towards the music practice seemed valuable for the nurses. During the last day of the MiMiC project in May 2017, a young male doctor joined the nurses' breakroom music-making for the first time. Afterwards, he rushed towards the musicians to tell them that he was sad that the project was coming to an end. He said that he was terribly disappointed that he had missed all of the sessions. Later, after the project ended, coordinating nurse Julia reflected in an interview:

> *Yes, I really like it that the doctors were more engaged than in the previous project, and that they just joined us in the breakroom […] I really like that they just joined us there.*

110 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 104).

111 Physiotherapist Reinder used German language words in his interview account: 'Menschen' meaning 'People' and 'Brüder' meaning 'Brothers'.

The nurses' perceptions of small changes in the hierarchical gap between them and the doctors through the shared musical experiences can be seen as relevant for their sense of membership and connectivity within the community of practice. This perspective is acknowledged by the Musique et Santé organisation in the forestudy (see Bouteloup, 2010 in section 2.1.2).

MUSIC AND DEMENTIA

Unlike the narrative data collected in the context of the MiMiC practice, the nursing home caregivers' interview accounts did not raise the issue of hierarchy within their community of practice. It can be speculated that the culture of work and the collegial structures are likely less pronounced than in the hospital work context. Still, in the Music and Dementia practice, the caregivers reflected upon seeing new sides of their colleagues in the musical situation. For example, activity leader Jane explained that she took part in the music project with two colleagues, whom she did not know well. Her thoughts were that one of the two colleagues was a 'rough' woman, who lacked gentleness in Jane's view. However, during the eight weeks of the music project, Jane came to see a new softer side of the colleague in the circle. Jane explains:

> *[I thought she was] a kind of a bulldozer. And then, I saw her with the residents [in the circle], doing things and I thought: 'You actually are an awfully sweet person.'*

Thus, it can be understood that the dialogical musical processes of the Music and Dementia sessions could foster social discovery among caregivers, as suggested previously by the forestudy on Music for Life (see section 2.1.1) and on Musique et Santé (see section 2.1.2).

5.2.4.2. Catalysis of communication and increase of interaction

In healthcare, the relational imbalances that manifest in the hierarchical structures of the work community (see also Youngson, 2012; Greham, 2012) exist also in the unevenness of power and dependency between the healthcare professionals and the patients or residents (see also Benner, 1984/2001). Smilde et al. (2014) point out the unevenness[112] of dependency between nursing home caregivers and the residents, and Benner (1984/2001) and Youngson (2012) write about the unavoidable vulnerability of hospitalised patients.

The nurses taking part in the MiMiC practice admitted that they found it difficult at times to connect with vulnerable patients even though they considered contact as important for the care delivery[113]. At times, the patients may have rejected the nurses' attempts to build a care relationship, or even resisted care altogether. When unable to access and connect with the patients, the nurses may have asked the MiMiC musicians to visit those patients who were finding it difficult to communicate with their nurses.

112 These relational imbalances between the people giving care and those in need of it can have an impact on their care relationship and the patients and residents' experience of the care (Youngson, 2012; Smilde et al., 2014).
113 The interviewed nurses emphasised the importance of communication and contact in the care delivery for giving person-centred care, which is in line with the notions by Kitwood (1997), Youngson (2012) and Van Heijst (2005).

Such was the situation with Mr. Boekman, a patient in the ward of traumatology, and coordinating nurse Werner giving care to him. Mr. Boekman was a farmer in his seventies who survived an accident that had left his leg fractured and in need of surgery. Due to the severity of his injuries, he had already spent two weeks hospitalised. In his one-person-room, pictures of his farm animals were placed on the walls. Mr. Boekman was confined to a wheelchair and he was struggling with his hospitalisation, which he projected on the nurses by disagreeing with them and resisting the care. Werner, in particular, was confronted by Mr. Boekman's unwillingness to cooperate with him, and so he warned the musicians about the risk of unpleasant interactions with Mr. Boekman. From Smilde et al. (2019, pp. 47-50)[114]:

> On the first visit, mediator Claire knocks on the door of Mr. Boekman. She approaches him carefully and peeks into the room. '*Come in, come in, I become so happy when I see someone!*', Mr. Boekman welcomes Claire into his space. Claire introduces herself and asks if Mr. Boekman would like to hear some music. '*That would be fantastic*', he answers. Then, he readjusts himself with the help of his nurse to a comfortable position so that the musicians can find a place in the room. Cellist Roy, [double bass player] Sebastian, and [violist] Lucy enter. '*The lady and the gentlemen can stand there…*', Mr. Boekman instructs with his hand to the musicians, who follow the instruction and take their designated places. Mr. Boekman asks them instantly: '*Will you play some happy music for me?*' Roy answers: '*If that is what you want?*' Researcher Rachel, who is observing the session peeks in and introduces herself quickly before the musical interaction growths: '*I am a colleague of Claire's, may I also come in and listen?*' She receives an answer without hesitation: '*The more, the merrier!*', Mr. Boekman shouts.
>
> The musicians then begin an uplifting improvised piece. Afterwards, they propose another piece: an improvisation of a landscape. Mr. Boekman would like to hear a landscape of his farm. When a beat is found, he starts to move his hands to the pulse and smile. '*That was wonderful. Super!*', he says while applauding. '*Beautiful, a misty landscape, beautiful picture*', he describes. The musicians offer to visit him the following day again. Mr. Boekman seems delighted and asks if he may shake the musicians' hands. After the handshakes, the musicians leave. As they pass towards the following room, Mr. Boekman talks to his nurse about his familiarity with dance music but adds that he has never heard music like this before. […]
>
> On the second morning, the physiotherapist finishes his work with Mr. Boekman right before the musicians arrive. At the sight of the musicians, Mr. Boekman starts chanting: '*Physio and musicians! Physio and musicians!*', expressing his excitement about the activities. Claire goes in first to make sure that he is ready for the music. He is. At first, Mr. Boekman confesses that he has a lot of pain in his leg. Then he lifts his blanket to show his operation scar. He continues: '*I expect the pain to have vanished by the time you have gone*', he says this with humour in his voice. When Roy, Lucy and Sebastian arrive, Mr. Boekman tells them that he would like to hear something happy and beautiful from the past times. The musicians propose a piece by Elvis: *Can't help falling in love*. Werner stays at the entrance and observes the musical moment. When the lingering piece of music is over, Mr. Boekman comments on it: '*I am glad, this was good for me. Now the pain is away. Before I was like 'ouch!' but now not anymore.*' Roy jokes: '*No need for morphine now.*' Mr. Boekman asks for another song, so he receives a cheerful Irish improvisation with an uplifting melody.

114 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 47-50).

Nurses gather to listen by the door, and they are smiling and applauding at the end of the piece. […]

On the morning of the third project day, the musicians begin the session by visiting other patients before meeting Mr. Boekman. Now they ask him what he would like to hear. At first, he says: '*Something sunny*', but then he adds: '*The one that you just played [in another room]*'. Hence, the musicians begin to play *The Blue Danube* by Strauss. The tempo is low at first but increases. Mr. Boekman is wiggling his toes and enjoying the music. '*Wonderful!*', he shouts. After that, he asks for '*a piece of spring.*' He adds that he misses the lambs on his farm and points at the lambs on the pictures hanging on his wall. Then, he specifies that he would like a piece of music about spring and his lambs. Again, as soon as the music takes off, his toes wiggle to the steady beat of the music. '*Wonderful!*', he shouts again. Lucy tells him that he inspired the musicians. […]

The following day, Mr. Boekman is already sitting in his wheelchair ready for the music when the musicians arrive. Lucy asks him if he would like to conduct the trio with the baton and guide them through the life at his farm. She initiates: '*We need your help to describe the place.*' However, Mr. Boekman refuses to conduct. He is not willing to do that, but he would be happy to tell about his farm in his own words. He starts talking, and there is no end to what he has to say. He describes in great detail at what time he starts to work in the morning; waking up at 05.15, starting the daily chores at 5.30. He tells about the tasks of cleaning the boxes of his cows and talks about his family as well. [Research-nurse] Ines, who is listening, asks him: '*What do you miss the most?*' Mr. Boekman answers that the people and the work at the farm are important for him. The musicians then proceed to play an improvisation with a streaming flow of melodies. Mr. Boekman is moving his feet to the music like the days before. At the end of the piece, he tells that it gave him relaxation. […]

On the fifth day of the project and in just hours, Mr. Boekman will be released from the hospital. Before the musicians enter his room for the last time, Mr. Boekman is already sitting in his wheelchair with a small handwritten paper note. It reads '*Ravel: The Bolero*'. That is what he would like to hear today. The musicians start by drumming the Bolero rhythm, and so the piece begins. Mr. Boekman is delighted. He listens carefully, sometimes looking out of the window of his room. He then says with a serious low voice: '*This made my day.*' As he will be going home back to his farm in a short while, the musicians propose him a '*going home*' piece. Mr. Boekman tells the musicians that it is a pity that the music will end now. Roy agrees: '*We also think it is a shame.*' The last improvised piece is energetic and rhythmical. Later, Roy brings the melody of the Bolero back to the improvisation, as a coda. Sebastian and Lucy join the recapitulation of the Bolero. '*One for the road*', as the saying goes. Applause follows, and Mr. Boekman gives heartfelt thanks to the musicians. He wishes them success in their careers.

Coordinating nurse Werner, who had warned the musicians on the first day of the project about Mr. Boekman's unpleasant and potentially unsettling behaviour, was faced with a new kind of an opening to Mr. Boekman's personhood through the music-making that had not come into light during the everyday care. The musicians' visits in Mr. Boekman's room seemed to allow the patient to come to terms with his hospitalisation in an unexpected way, as through the person-centred improvisations he was able to be reconnected with the farm life and home that he desperately missed. This reconnectedness was subsequently reflected back as a new openness to communicate – not only with the musicians but in particular with the nurses, who had struggled to connect with Mr. Boekman. On the second

day, in a debrief meeting after the music session, Werner excitedly told the musicians that Mr. Boekman seemed to benefit from the music sessions, and that he was opening up to the nurses more than before. Mr. Boekman was behaving completely differently with the musicians than he did earlier with the nurses.

It seemed that Mr. Boekman's openness to communicate with the MiMiC musicians could catalyse new opportunities for contact between him and Werner, who had observed the musical interactions closely by the doorway. Later in an interview, Werner reflected (from Smilde et al., 2019, p. 49)[115]:

> *I found it very striking in this patient, who was alone in his room, and with whom I had problems with how he approached people and how he approached myself fourteen days ago, and whom I now saw becoming a different person. Full of stories. And now I saw what I just explained: certain emotions emerged; what he had experienced in the past. And there he was!*

Werner's account of his new insights into and contact with Mr. Boekman, seeing the person behind the patient, highlights the significance of musical engagement as a catalyst for communication in healthcare. Also, Werner's reflection underlines how the core aims of person-centred care, seeing and respecting the patient as a whole personhood instead of concentrating on the treatment of illness (see also Kitwood, 1997; Van Heijst, 2005), can be reinforced through music-making.

It appears that Werner's new understanding of Mr. Boekman's personal processes, which underpinned his behaviours that emerged in the musical interactions, benefitted the development of the care relationship between them. Werner explained in an interview (from Smilde et al., 2019, p. 50)[116]:

> *I think [the music sessions bring] more understanding of each other. I think that is the most important thing. For example, when a patient is really grumpy and closed up during his stay in the hospital. Then sometimes you think: 'Must it be like this?' But if you then hear the history behind this, which comes out through the music, then you often hear stories of the patient, and you think: 'Yes, I can put it in perspective; why this happens like this.' And that is very important, really.*

Werner's new insights into Mr. Boekman's personality through the music-making remind of the discoveries in the forestudy of this research (see section 2.1). For example, the Musique et Santé practice aims to provide patients with an expressive musical outlet to open "a *window […] to the outside world*" (Bouteloup, 2010, p. 2). The concept of a window to the outside world is clearly relevant in the case of Mr. Boekman, to whom music helped reconnect with his life at the farm that he so deeply missed. This also helped him to respond to his care more collaboratively. Second, the Musique et Santé practice aims to create a dialogue through music that can serve as a common ground for "*a climate of trust between hospitalised people, families, and healthcare staff*" (ibid., p. 2). Building trust between patients

115 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 49).

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and nurses through musical engagement is notable in Werner's reflections on Mr. Boekman and the MiMiC practice. According to Cohen-Salmon (n.d., see section 2.1.2), the dialogical musical processes can help healthcare professionals to rediscover intersubjectivity in their care delivery, which is also evident in Werner's reflections on his care relationship with Mr. Boekman.

Furthermore, the core premise of the Music for Life practice that the emerging social processes in the music-making can serve the relationship-building between caregivers and residents (see forestudy in section 2.1.1) is crucial here. Cellist Lucy Payne states in the forestudy on the Music for Life practice: "*[…] it strips away a lot of [the participants'] fronts. Strips away; you can get to a core of what people are*" (see section 2.1.1). Based on the analysis of Mr. Boekman and Werner, Payne's account fits within the medical context of the MiMiC practice and provides insight into the changes in Mr. Boekman's interactions with the musicians and, later, with Werner in particular. Payne's comment also links back to the concept of a performative front as proposed by Goffman (1959/1990). It can be understood that musical interactions simultaneously help the patients and residents to be reconnected with their sense of *personhood* (see also Kitwood, 1997 in section 1.2) and facilitate the observing healthcare professional(s) to relate to them on a deeper level of *fellow humanity* (Van Heijst, 2005 in section 3.3.3.3). Subsequently, a new channel of communication between them may be established.

A similar observation was made by nurse Amanda in a group discussion after a MiMiC project (from Smilde et al., 2019, p. 108)[117]:

> *You get something more to share, you could say. Except for 'You are a patient, or you are a nurse', but at that moment we are all people who are talking about music. That brings about fun topics. Something besides the hospital, the illness, the pain. I found it nice that one gets just a bit more of a human relationship instead of 'nurses and doctors.' Coincidentally, there was a physician coming into a patient room and he had to wait for the music to end. He really liked it, which was special to see. And then you begin the conversation about the music and not immediately about the condition.*

Here, it can be interpreted that the person-centred approaches of music-making created possibilities for new person-centred encounters in healthcare, and furthermore, they helped to balance out the uneven relationships between healthcare professionals and patients or residents (see also Bouteloup, 2010, p. 2). Nurse Amanda narrated about the development of a "*human relationship*", which reflects the call for *fellow humanity* in healthcare (see Van Heijst, 2005, in section 3.3.3.3).

PERCEIVED INCREASE OF INTERACTION AND COMMUNICATION AMONG PATIENTS AND RESIDENTS

The catalysis and increase of communication could, furthermore, bring about social changes among the patients sharing a hospital room during a MiMiC project, as well as the residents co-participating in the Music and Dementia circle. In the Music and Dementia

117 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 108).

practice, the catalysed communication between the residents in the music sessions could create new mutual relationships in the long-term care. Caregiver Loes explained:

> *They seek each other out more in the evenings now. They seek each other out and say: 'Oh, come and sit next to me.' […] I do think that the music has helped in that respect.*

The caregivers perceived the increased sense of connectedness as crucial for the residents' well-being. Caregiver Anna reflected in an interview:

Q: *And what can [the increase in social interactions] mean?*

Anna: *Well, that there is more of a connection in the group. More togetherness.*

Q: *Hmmm.*

Anna: *Yes, togetherness.*

Q: *And is that important in the…?*

Anna: *Yes, I think so. But I think it is important, because otherwise people are isolated and on their own.*

Q: *Hmmm.*

Anna: *Yes, and that occurs quite naturally. Everyone lives in their own little bubble and does their own thing. And then, you try to bring them a bit more together through the [musical] activity.*

The concept of togetherness aligns with previous findings on social changes that are brought about by participatory music-making in nursing homes (see Gould, 2012; Smilde et al., 2014; and the forestudy on Music for Life in section 2.1.1). Creech et al. (2014) refer to the emerging of *fellowship* as one of the key social-emotional benefits of musical participation in later life (see section 3.3.4.1).

In the MiMiC practice, the social changes described above seemed to occur between patients who were sharing a room. Coordinating nurse Gina explained in an interview that in recent years the patients have been less engaged with each other during their time of the hospitalisation, which can be disadvantageous for recovery. According to Gina's observations of the MiMiC sessions, the music-making could help the patients to connect with each other socially. Gina recalled:

> *At once, there is this feeling of being connected, and that is not there just because of people being in the hospital together. In the old days, this was the case, when there was no TV or internet [in the room]. People used to support each other much more. And now, you see it emerging again; there is much more contact between patients, in fact. It might not be the same for everyone, but I just notice that [the music-making] brings it back.*

Gina's observation, "*At once, there is this feeling of being connected*" is powerful support for the interpretation that the music sessions catalyse interaction and fellowship (see Creech et al., 2014 in section 3.3.4.1) among the patients. It can also be interpreted that, from the nurses' perspective, increased interaction between patients through the music-making may be beneficial for the patients' recovery, as social connectivity can diminish feelings of isolation. Thus, it can contribute positively to the patients' experiences of the hospitalisation (see also Youngson, 2012; Ryan et al., 2014 in section 1.2). The patients' mutual communication can, furthermore, develop into mutual compassion.

Previously in this dissertation[118], the MiMiC music visits which took place in Mr. Smit and Mr. Kleine's shared room have been used for exemplifying various social processes: the emergence of a community of practice between the musicians and the nurses, the situational nature of the nurses' musical participation, and the experienced transportation through music-making. Once again, a moment of the MiMiC project, where the musicians proposed a shared improvisation for Mr. Smit and Mr. Kleine can serve as an example of the nurses' perceptions of emerging compassionate contact among patients. From Smilde et al. (2019, pp. 41-42)[119]:

> On the sixth day of the project, clarinettist Jonas explains to Mr. Smit and Mr. Kleine that the musicians would like to make a piece inspired by the men themselves. He asks what their respective favourite colours are. Mr. Kleine is quick to answer '*green*'. Mr. Smit takes a moment to think: '*Hmm… blue.*' The musicians then propose to make a piece going from the colour green to blue. Coordinating nurse Jessica stands listening and observing by the doorway to the room with mediator Rachel.
>
> The piece begins with a clarinet melody accompanying the cello. The colour green has a river-like streaming motion and a minor tonality. Then, as the men are watching the musicians and listening intensively, the melody passes on to the bass flute, played by Madelief. Mid-way through the piece, the colour and the mood of the piece change. Roy plays soft arpeggios on the cello, and Jonas and Madelief bring the piece to a major tonality with two parallel melodies on their woodwinds. When the colour changes, Mr. Kleine glances at Mr. Smit smilingly, as if to ask him '*Do you enjoy it, too? See, they arrived at your colour now!*'

This moment of connectivity through the shared improvisation described above is significant on multiple levels. First, the patients had been separated by curtains for most of the days leading to this moment due to Mr. Smit's wound care (see section 5.1.4.1). Hence, the patients had had little contact with each other during their hospitalisation. The music sessions were instrumental for catalysing social interaction between them, especially when they had been separated by curtains (see also Smilde et al., 2019, pp. 39-43). Second, the two men had experienced severe pain and excruciating tediousness during their stay in the hospital, which could be heavy and dispiriting. Being brought closer together through the improvisation, Mr. Kleine could be seen displaying care for Mr. Smit by glancing at him warmly.

Such a small gesture of caring and compassion was highly meaningful for the nurses

118 See again in sections 5.1.4.1, 5.1.4.2 and 5.2.3.2.

119 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 41-42).

working towards the patients' recovery and well-being. Coordinating nurse Jessica, who observed the exchange between the two men by the doorway, reflected later in an interview (from Smilde et al., 2019, p. 42)[120]:

> *The most wonderful moment was the two gentlemen together. That the other man kept looking around the corner to check: 'Are you enjoying this as much as I am?' I thought that that was really the most beautiful part. That the patients had an interaction about [the music]. While otherwise, they might not talk to each other. Now simply asking: 'Are you okay today?'—'Yes, I'm okay'.*

From this example it can be understood that the perceived increase of compassionate communication between the patients not only benefitted the recovery process of the patients, but it was also highly fulfilling for the healthcare professionals, as it evoked *sympathetic joy:* the warm feeling of rejoicing for the well-being of the other (see also Ricard, 2013 in section 3.3.3.2).

Similarly, in the context of Music and Dementia, the experienced social changes between residents could be significant for the caregivers and the care itself. For example, in one observed project, a man named Jim was participating in the circle. Jim was in his sixties and he was in an early stage of dementia. His dementia had caused him to behave aggressively towards other people. That is why he lived in the nursing home, although his wife still lived in their home close by. Jim's dementia caused him great pain and sadness. He had previously behaved aggressively in other activities. Because he was known for having played the accordion earlier in his life, the caregivers asked him to join the music project in hopes that his behaviour would improve. Reconstructed from the fieldnotes:

> During the fourth session, Jim seems settled down and calm on his seat. He is smiling ever so slightly. Workshop leader Mieke has chosen bells to be passed around in the instrument round. When she offers them to Jim, he quickly offers them to resident Janneke, who is sitting in a wheelchair next to him, instead. Jim seems to want Janneke to play the bells together with Mieke. Recognising Jim's intention to encourage Janneke to play, Mieke shifts her focus on Janneke, too. However, Janneke does not take the instrument, and so, caregiver Mona takes the bells, instead. Mona starts playing a steady beat by shaking the bells and Mieke begins singing: '*What is sounding so beautiful?*' A violinist joins in to accompany her singing. Janneke listens to the music silently with a focused expression on her face. After the piece ends, Mieke asks Jim once more if he would like to play the bells. This time he accepts. Jim's feet are keeping the pulse as he shakes the bells *taa taa ti-taa-ti*. With a cheeky smile on his face, Jim is playfully joking about throwing the bells across the room at caregiver Theresa. Theresa chuckles as a response.
>
> Jim's playing keeps getting smaller and smaller, until he suddenly increases it again. In the middle of the piece, Jim attempts to give the instrument to Janneke again, and this time he shows her: '*See? You play it like this*' with a hand demonstrating the shaking movements in front of her. Janneke does not respond, so Jim plays a final coda as a solo before handing the instrument back to Mieke.

120 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 42).

In the reflection debrief, a care coordinator looked back on the moment when Jim gave the bells to Janneke. "*It was really beautiful*", she told. "*He made contact and tried to facilitate [Janneke] to play*", she explained. Later in an interview, Jim's caregiver, Theresa, reflected:

> *I do notice [changes in] Jim, to whom I give care. […] I see that the music releases emotions. He is having a hard time. He does not actually want to be here [in the nursing home]. His wife lives close by and he really is having a difficult time here. I think that [the music] helps him to release emotions: anger but also sadness, and he can let them go now more.*

It seems that the musical engagement helped Jim to self-regulate his emotions and so, it supported his self-production in a challenging new life situation, where his internal preferences and the external conditions were in conflict (see also DeNora, 2000 in section 3.1.6). Finding ways for sustaining his self-production through the musical engagement appears to have helped Jim become more compassionate towards the other residents, like Janneke as well. In the care coordinator's comment "*It was really beautiful*", it can be argued that the observed social changes towards increased communication among the residents evoked sympathetic joy in the caregivers (see later section 5.2.5 on Emotions.)

5.2.4.3. Development of care relationships: person-centred music-making, intimacy and flourishing

In the observed settings of the MiMiC and Music and Dementia practices including the patients' rooms, the nurses' breakroom or the circle, the participatory music-making seems to have created connected moments of Kairos that were charged with potential for profound mutual contact (see section 5.1.4.2). In the case of Janneke and her long-time caregiver Mona, who co-participated in the Music and Dementia sessions (see section 5.1.4.2), the music-making appears to have fostered a deeper sense of connectivity than the everyday care. Mona reflected in an interview:

> *It is truly a moment when you are simply really only here for the resident who sits next to you. Like Janneke, when she is emotional, you just have some quiet time with her.*

The deepening of the care relationship appears to be connected to the intimacy of person-centred music-making, which allowed the healthcare professionals and the residents or patients to engage with each other closely in musical situations. In both music practices, the healthcare professionals emphasised that the intimacy of musical moments fostered feelings of closeness. Nurse Jasmine confirmed:

> *Very intimate. It is naturally a small space where to stand in and you are very close to each other, and the musicians are making eye contact. It evokes something in a person.*

Jasmine's description links to the concept of presence which emphasises authentic and undivided contact in social interaction (see Benner, 1984/2001; Van Heijst, 2005 in section 3.3.3.3).

The experienced intimacy of the music sessions may have cultivated a deepening

sense of connection between the healthcare professional and the patient or resident, which could have an impact on the development of the care relationship. For example, nurse Frederik, who initiated a birthday surprise for his patient Mr. Noor (see section 5.1.4.1), sharing musical moments with his patient helped him to get closer to Mr. Noor. Nurse Frederik explained in an interview:

> *Well, at first [the relationship] was a bit distant, I think, between myself and [Mr. Noor]. Once someone has heard a piece of music that [the musicians] offer and it is what [the patient] likes, then you'll see them opening up, and you just get more input to start a conversation with someone like that. I think that is very special.*

In the development of Frederik and Mr. Noor's care relationship, as in most of the interview and group discussion narratives in this research, the deepening of the care relationship through participatory music-making had to do with diminishing distance and detachment. Frederik continued:

> *I found it special that the music touched him so much. Ordinarily, in a normal conversation, he is a very calm person, really, and he does not get very excited. […] But to see someone flourish like that! Afterwards my connection with [Mr. Noor] was totally different. He was so joyful. That was very special.*

Flourishing through music (see DeNora & Ansdell, 2014) was again recognised in Frederik's account. The shared moment of Mr. Noor's perceived musical flourishing worked, furthermore, as a change agent for the deepening of the care relationship between Frederik and Mr. Noor. Frederik further described how these experienced moments of flourishing and the deepening of the care relationship impacted[121] his job satisfaction:

> *Well, the work atmosphere becomes more relaxed. For sure, we are more relaxed, and the patient is relaxed too. You are able to talk to each other easier, and I think that it is a huge benefit.*

This development of the care relationship, through the catalysed communication and interaction between the healthcare professionals and patients or residents in the music sessions, resonates with the aims and values of person-centred care (see Kitwood, 1997 in section 1.2.). Furthermore, as implied in Frederik's account, the development of communication with the patient can be beneficial for the quality of the care delivery: "*You are able to talk to each other easier, and I think that it is a huge benefit.*" Thus, it can be understood to support the healthcare professionals' care delivery and job resources (see also Bakker & Demerouti, 2014 in section 3.3.3.5.).

To exemplify a moment of person-centred music-making, where the music as a stimulus for communication seems to blend into a nurse's workday, an episode in the MiMiC practice stands out. Reconstructed from the fieldnotes:

121 See sections 5.3.4 and 6.1.2 on the experienced support for job resources, social changes and experienced impact of the music on the work of the healthcare professionals.

Two patients in their late mid-life, a man and a woman share a room. The musicians, clarinettist Jonas, cellist Roy and flautist Madelief, are visiting them now for the first time. Nurse Merel is present and stays in the room for the music-making. Before the musicians can start, Merel first helps the woman to sit upright and silences her beeping monitor. On the other side of the room, while Merel is getting the woman ready for the music, the musicians chat with the male patient.

When the situation is ripe for music-making and the sense of haste disappears, clarinettist Jonas explains that the musicians could make a special piece for the participants; a landscape. He asks the patients where they would like the music to take them. The patients want to hear a piece of a sea and the beach. Nurse Merel adds that she would like to hear a landscape of winter sports. Jonas answers that the musicians will begin from the sea and the beach, and from there, go to a snowy place of winter sports. Everyone agrees with smiles and chuckles.

The piece begins with a motive of triplets imitating the waves of the sea. The motive grows into a warm cello solo, followed by a soft solo on the flute. Then, the musicians start to play motives imitating the motion of a skier sliding down a snowy hill. When the music comes to an end, the man comments: '*The first part was clearly a sea*.' Nurse Merel laughs: '*There was a slope, too!*'

Afterwards, the musicians play *I want to break free* by Queen as a request of the patients. Then, the musicians begin to make their way to continue their visits in other rooms. They finish the session, and while they are on their way out of the room, nurse Merel and the female patient stay still and go on talking about the improvisation of the two landscapes.

In moments like the one described above, where the nurses' agency was fostered in the music sessions, person-centred music-making also offered possibilities for them to display *compassionate care* (see also section 3.3.3.1) through the musical processes as actively relating to and connecting with the patient on a level of fellow humanity.

Looking back on the case of Mr. Smit and Mr. Kleine, nurse Amanda agreed to participate in the musical visit with her patients (see previously in section 5.2.3.1.). The musicians found a way to include her by asking her for input for a piece; what *she* would wish for the two men. As a nurse to Mr. Smit and Mr. Kleine, and knowing their struggles towards recovery, Amanda was able to display compassionate care to the men by wishing them a piece of relaxation. Amanda reflected in Smilde et al. (2019, p. 43)[122]:

> *That was quite special to be part of it […] If you sit in the middle in this way, that somehow feels pretty intimate, really.*

In Amanda's reflection, the notions of intimacy, presence and inclusion are again highlighted.

5.2.4.4. Interactions with the musicians: perceived kindness and personal recognition

When it comes to the healthcare professionals' experiences of the musicians' interactions with the patients and the residents, kindness and friendliness emerged frequently in the narrated reflections. Remarkably similarly, the caregivers and the nurses shared a mutual

122 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 43).

view that the musicians' interactions were characterised by a deeply rooted amicability and calmness. Caregiver Theresa summed in an interview: "*It is the kindness and the tranquillity.*" Similarly, coordinating nurse Julia reflected:

> *I really enjoy the atmosphere that the musicians bring to the wards: 'We really want to play for you; to support your well-being; so that you feel better.' It really shines through [the musicians]. They are there to play and they seem to enjoy it too, but they really bring a moment of something special just for the patients. That shines through and it brings calmness to patients.*

It can be interpreted that the musicians' professional values and approaches of person-centred music-making (see also Smilde et al., 2014, 2019 in section 3.2.5) were considered as supportive to moments of flourishing, as emphasised in Julia's account, "*they really bring a moment of something special just for the patients.*" Here, the concept of the *hospitality* of community music and participatory music practices is applicable. Drawing upon Derrida's (2000) notion of *absolute hospitability*, Higgins (2008, 2012) and Lines (2018) describe that community musicians aim for full acceptance and an inviting disposition towards the persons in the participatory music practices (see section 3.2.5). Invitation and hospitability are at the core of the inclusive values of participatory music-making (Turino, 2008). In line with Turino (2008), it can, thus, be understood that the musicians' tailor-made approaches of person-centred music-making, paired with the intention of hospitability and an invitation to participation, resonated with the healthcare professionals' positive experiences of the music practices.

Furthermore, the musicians' perceived kindness and hospitability appeared to nurture a sense of personal recognition among the healthcare professionals beyond observing the interactions between the musicians and the patients or residents.

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In the 'backstage region' of the MiMiC practice (see also Goffman, 1959/1990 in section 5.1.4.3), where the music was made with and for the nurses in the coffee breakroom, the nurses experienced the musicians' visits as a special acknowledgement. Nurse Lena reflected:

> *Anyway, it is quite an honour to have someone play for you, that is simply amazing. And the music was just so beautiful, so it makes you happy, and it provides a welcomed distraction. It brings you a moment of peace. I really felt that quite strongly.*

During the MiMiC musicians' visits in the patient rooms, being included in the musical processes together with the patients also supported the nurses' experience of personal recognition. In an interview, nurse Josephine reflected:

> *It was quite fun, too, because they did an improvisation piece about what kind of a nurse I am. And the patient replied with one word: 'enthusiastic.' And then, they improvised around that word. I could not help laughing, because I recognised it immediately. The piece was so fitting and so much like the word [the patient] had chosen. And [the patient] was looking at me like:*

'how is she going to react?' But I liked it immensely because I really recognised how I am like that sometimes. […] It brought me happiness. I loved it that it became a piece of us two together. And that [the musicians] brought me closer to that patient. And naturally, it is so special that a piece is made just for you. Then you feel honoured too.

Nurse Lena and Josephine's narrated upon feelings of 'being honoured' imply that the musicians' hospitable interactions were not only professionally meaningful for the nurses, but also significant on a personal level. Being recognised personally beyond the professional nursing role – like Josephine being recognised as an enthusiastic person – or feeling honoured by the musicians' personal devotion can be considered as relevant for cultivating positive emotionality at work and building a compassionate care culture, as previously suggested by Youngson (2012) and Ricard (2013). Furthermore, the described feelings of inclusion and recognition are again in line with the core values of participatory music-making (see also Turino, 2008, pp. 33 in section 3.2.5).

5.2.5. Emotions: responses to and resonances within shared musical experiencing

The analysis of this research suggests that emotional responses to the participatory processes of music-making are central for describing and interpreting healthcare professionals' experiences in the two music practices, MiMiC and Music and Dementia. When it comes to emotional responses to the music-making, the healthcare professionals often seemed to primarily respond emotionally to three social processes taking place in the music sessions. First, seeing the patients or residents to whom they give care being engaged in the music-making, and observing their emotional responses to the music, the musicians and each other (e.g., nurse Frederik and Mr. Noor in section 5.1.4.1). Second, seeing one's colleagues' emotional responses to or agency in the music sessions (e.g., activity leader Jane's new collegial insights in section 5.2.4.1). Third, being moved by the music and by the musicians' personal attention (e.g., nurses Lena and Josephine's feelings of acknowledgement and recognition in section 5.2.4.4).

Emotions are central to Dewey's (1938/2015) theory of learning, as the process of meaning-making is often evoked by an emotional response to an unfamiliar or new experience (see section 3.1.4). Emotional experiences can, therefore, be processed through reflection and eventually, become learning experiences and develop into new knowledge (Elkjaer, 2009 p. 80).

5.2.5.1. Emotional responses to the processes of person-centred music-making

Through observing the patients' or residents' emotional responses to music-making, healthcare professionals often gained a new understanding of the patients or resident's personhood, which could be emotionally moving to them. For example, caregivers Mona (see section 5.1.4.2) explained:

With [resident] Janneke, I have actually never before seen her getting so emotional. Like, you see that she becomes emotional and that is beautiful to see. So, I saw a bit of a different side of Janneke now.

The expressed value of the mutually emotional responses is in line with the person-centred care values, which highlight dialogical interactions between the care provider and care recipient, as well as the recognition of one's personhood beyond their condition (see also Kitwood 1997; Zeisel, 2010 in section 1.2).

Similar to Mona's account, the nurses in the MiMiC practice described their perceived value of the patients' emotional responses to the music-making. Sometimes, the patients' emotional responses also brought about new or unexpected insight into the patients, which could change the healthcare professionals' perception of them, as in the previous case of coordinating nurse Werner and Mr. Boekman (section 5.2.4.2). In another example, nurses Jasmine and Erica discussed a patient whom they came to see in a new way through the musical interactions of the MiMiC practice. From a group discussion transcript:

Jasmine: *I noticed that in the conversation, the person behind the patient emerged. There was one patient, I don't know who that was anymore, but it doesn't matter. He suddenly spoke about certain pieces of music that he found beautiful and special, and then, he went on to tell me what he knew about [the pieces] and about the situations he knew them from. And then I thought: 'Woah, the man knew all of that.' Suddenly a different side emerged.*

Erica: *Another side.*

Jasmine: *Yes, another side of the patient emerged, and that was really beautiful to see. Besides him being ill.*

Erica: *And the emotion of the man who was about to go home and who was in a rather good condition physically. I do not think we would have gotten to see that [expression of emotion] if [the musicians] had not been here. Then we would have had just…*

Jasmine *He would just have gone home.*

Here, the patient's expression of emotion through music can be interpreted as meaningful for the two nurses. This aligns with Turino (2008), Finnegan (2012), and Hesmondhalgh's (2013) works on the socioemotional significance of music, where they argue that music is a resource for emotions which have primarily social value of connecting people (see section 3.3.4.1). Similarly, seeing the emotional responses of colleagues can be seen as meaningful for the social bonding of the community of practice. For example, in the MiMiC practice, doctor-in-training Caroline reflected:

> *Yes, I think that [the music-making] creates a connection between people, also among the nurses themselves […] [the music] just opens up people. They become more open towards each other. That is very valuable.*

Observing one's colleagues' responses to music seemed to foster new understandings into how others process emotions. Nurse Frederik explained:

I also noticed this in the breakroom, because everyone, indeed, deals with [emotions] differently. You see occasionally someone look down or, well, find them in their own worlds. [I have learned] that everyone processes [emotions] in a different way.

This kind of new knowing that Frederik describes is connected to the previously portrayed processes of seeing new sides of one's colleagues within the community of practice (see section 5.2.4.1).

Finally, the healthcare professionals' acknowledgement of their own emotions, which were catalysed by the music-making, seemed to be an important part of making sense of their experiences of the music practices. The nurses and caregivers frequently provided similar descriptions in the interviews and group discussions of how they experienced the music as an 'entering'[123] force. It can be interpreted that the music-making penetrates a layer of the healthcare professionals' *professional habitus;* the presentation of self at work (see also Goffman, 1959 in section 3.2.4), as also suggested by the forestudy on Music for Life (see section 2.1.1). The musical experiencing can also allow the healthcare professionals to access their imaginative and emotional selves at work. Coordinating nurse Gina explains:

Through listening, you can 'run a piece of a film' for yourself or visualise what you want to see. But because of the music it becomes even more real in my opinion, than only a picture in front of your eyes. […] It makes it a vivid experience and it touched me [emotionally]. […] That is what music does. At least it does to me. It leaves me very emotional.

Here, the evocative potential of person-centred improvisations for the healthcare professionals' imagining and sense of transportation through the music is once again emphasised (see section 5.2.3.1). Gina's reflection leads to the understanding that the narrated upon musical experiences foster *enhanced subjectivity* and resources for emotionality at work (see also DeNora, 2000; Turino, 2008; Hesmondhalgh, 2013 in section 3.1.6). In line with the pragmatic epistemology of this research, the notion that participatory music-making evokes imagination and emotions is fitting, as pragmatism considers imagination and emotional responses as central to the processes of experiencing (see also Dewey, 1938/2015). Furthermore, Turino's (2008) notion that one of the central functions of music is to evoke imaginative and emotional connections between the music itself and people's meaning-making of it (p. 7, see section 3.1.6) is relevant for the conceptualising of this analysis.

There were also healthcare professionals who acknowledged that they were not moved emotionally by the music-making, but still had a profound appreciation of it. For example, nurse Aurora explained:

I don't allow myself to become easily touched by [music], but I have often sat here [in the MiMiC sessions] and could not help laughing and I have gotten goose bumps, too. I have had this experience many, many times, but it still does not touch me that easily. I don't get emotional easily, but I still think it was very beautiful.

123 In the Dutch language, the healthcare professionals call the experience of their own emotional responses to the music-making as: "*Het komt binnen*", meaning "*It enters.*"

Again, it appears in Aurora's reflection, that letting deep emotions surface through musical participation is a question of self-allowance. Aurora's statement "*I don't allow myself to become easily touched by the music*" aligns with the previous findings on the processes of self-allowance to participate in the music sessions (see section 5.1.3.1). It also appears that particularly deep emotions seem to make the nurses' feel vulnerable, and thus, the nurses suppress them. It can be speculated that the need to suppress deep emotions may a coping strategy for establishing professional distance, which is in line with the understanding that the nursing profession "requires the ability to cope with high emotional demands" (Ten Hoeve, 2018, p. 143).

5.2.5.2. Empathic experiencing through music: emotional resonance with 'the other'

As explained in section 5.2.2, the healthcare professionals' experiences of the music practices seem to be deeply intertwined with their perceptions of their patients or residents' experiences of the music-making. When it comes to the emotional resonance between the healthcare professionals and the persons in care during the music sessions, this interconnectedness is particularly salient. For example, nurse Miranda reflects:

> *Well, we also see a lot of human emotions. Naturally you see that a lot here; what [the music] evokes in the patients and in us, too. […] I can enjoy that the patients are enjoying it.*

Many of the narrative accounts highlight *empathy* (see section 3.3.3.1) as an essential component of emotional resonance.

MUSIC AND DEMENTIA

In the context of the Music and Dementia practice, caregiver Mona's interview account emphasised her empathic resonance with the residents. Mona reflected:

> *I also found it quite emotional. Primarily because of the residents' emotional responses.*

Empathy towards the patients' or residents' musical experiences was expressed primarily in two ways. First, as empathising for the situation of 'the other' and second, emotionally reflecting the musical experiences from 'the other's' perspective. These aspects are characteristic responses of *empathic emotionality* (see also Ricard, 2013 in section 3.3.3.1). These aspects of empathic emotionality are well-presented in a group discussion fragment related to a Music and Dementia project. From a group discussion transcript:

Q: *What kind of emotions do you experience in the music sessions?*

Eleanor: *More joy and a lot of pleasure, and actually, I have also become a bit sad because*

Rebecca: *…I wish this could be available [for the residents] during the whole day.*

Eleanor: *Yes!*

Rebecca: *You want them to have this the entire day. They become so joyful and then they have to go back to the ward, and then… some people can be really sad.*

Mathilde: *[The residents] are back to the way they were before the music session.*

Eleanor: *So miserable, helpless. It is just sad. I do not pity them, but I just find it really sad.*

Rebecca: *You really feel for them.*

Eleanor: *Yes, but also the joy! I come home every Friday filled with joy [after the session] because I love the way people open up [in the circle]. And you would indeed like to see a lot more of that.*

This exchange exemplifies the two faces of empathic resonance: empathising with the suffering of 'the other' and taking the perspective of 'the other's' experience. What is striking is that Eleanor distinguishes her empathy towards the residents from pity, which is in line with Ricard's (2013) notion that pity should not be confused with empathy or compassion (see section 3.3.3.1). Instead, the profound altruistic motivation to end the suffering of the residents is prominently present in the caregivers' group discussion.

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Many of the interviewed healthcare professionals acknowledged their emotional resonance with the people to whom they give care. Doctor-in-training Caroline reflected upon emotional resonance in an interview after a MiMiC project:

> *Of course, we are all people. So, we all feel for others, also with the people you look after or who are in your care.*

In their narrations, many of the healthcare professionals framed this kind of an acknowledgement within specific moments of the music practices. In these episodic narrations, the nurses' empathy for their patients was emphasised in their tendencies to place the patients' experiences of the music-making at the centre of the music practice. From a group discussion transcript:

Jasmine: *It is just [the patients'] moment when the musicians are there for them.*

Erica: *Yes, really just for them … Yes, they are central.*

Jasmine: *I find that especially important for the patient. And emotionally, I have not gone through so much.*

Erica: *No, and at the same time, I also found it moving to see the partner who is next to [a patient] and who experiences [the music] so strongly, so to speak. That the two of them really have that moment. Yes, that is very special. And I also find that once you have*

been there, the patient also connects with you about other things faster too. He had made a connection with you in that moment.

Jasmine: *Yes, indeed.*

In this dialogue, the expression of empathy towards one's patient is clear, although the narration of one's feelings about the music-making is tentative, especially in Jasmine's account. Similarly, although not emotionally impacted by the music, Erica describes how she became emotionally moved by seeing her patient receiving music with his partner. Emotional resonance with patients is known to be an essential part of cultivating positive emotionality in the nurses' working life, as emotionally charged work experiences are connected to both work commitment and job satisfaction (Ten Hoeve, 2018). Therefore, it is relevant that the collected interview accounts and group discussions of this research reveal that the music practices in both care contexts evoke meaningful emotional resonance in the healthcare professionals. However, as Bloom (2016) points out, empathy in the healthcare profession poses a risk of *empathic exhaustion* (see section 3.3.3.4). Thus, empathy alone is not enough to support healthcare professionals' occupational well-being (ibid.).

Earlier in this dissertation, a moment of celebration in the nurses' coffee breakroom was described (see section 5.1.4.3). In it, a group of nurses celebrated nurse Linda's birthday. As a surprise, the MiMiC musicians asked her to conduct them. Later, in a group discussion, physiotherapist Reinder reflected upon the meaning of the musical moment:

Joyfulness, fun, cosiness, togetherness, a bit of attention to the person whose birthday it is. Just a fun, cosy, enjoyable way of doing things; supporting each other, actually. Having that moment together celebrating someone's birthday. That adds value to the moment.

In Reinder's reflection, the meaning of the moment seems founded upon positive emotional resonance. The described feelings of enjoyment, togetherness, support and belonging align with the concept of *flourishing* within the PERMA framework of well-being; in particular positive emotions, engagement, relationships and meaning (see Seligman, 2011 in section 3.3.2).

5.2.5.3. Fellow humanity beyond the professional front: allowing oneself to become emotional

In this research, I have observed many highly emotionally charged moments during the music sessions in both care contexts. Yet, in only a few of them have I seen the healthcare professionals being openly moved by the situations. Although their interview accounts reveal deep and profound emotional resonance with the people to whom they give care within the shared musical experiences, the healthcare professionals seemed to refrain from showing their emotions in the moment of music-making, or they distanced themselves from emotionally charged situations altogether. One such situation took place during a MiMiC project, when musicians Roy, Madelief and Jonas played Robbie Williams' *Angels* for a terminally ill woman and her grandson on the woman's last day in the hospital, before she would go home to die. From Smilde et al., (2019, pp. 44-45):

> […] When [cellist] Roy – after greeting Mrs. Mulder and her grandson – starts by telling that the musicians will play *Angels*, the grandson in the meantime moves onto a chair at his grandmother's side. *'We have rehearsed really hard, especially for you'*, the musicians say. Mrs. Mulder seems pleased with the thought that the song will be performed. Her voice sounds loud and clear, in contrast to yesterday. Has she come to terms with what is going to happen? Nothing more is being said; the musicians go straight into playing. The song opens statically and moves on with a steady pace. […]
>
> Slowly the sounds grow, and the main melody fills the room. At the second verse, the clarinet leads, and the other musicians support vocally. This gives the rendition of Robbie Williams' song a fragile brilliance. [Doctor-in-training] Caroline's eyes start to glimmer from tears and soon she cannot hold them. She allows them to run across her cheeks. […] In the last refrain, [Jonas'] bass clarinet plays some beautiful arpeggios.
>
> There is no silent moment after the last note. Mrs. Mulder instantly starts talking when the musicians are still playing their last notes: *'Utterly beautiful. Utterly beautiful'*, as if wanting to save the young people at her bed from feeling uncertain. She wants to applaud; the grandson removes the blanket so that her hands are free to clap. When the musicians let their instruments rest, it becomes clear that they are highly affected by what happened in front of them. [Clarinettist] Jonas turns his face to the wall, seeming uncomfortable; his eyes are red and filled with tears. […].
>
> Roy says that it was wonderful to arrange this song, as it can now be added to the repertoire. [Flautist] Madelief engages most with the patient in the moment after playing and adds that she thinks it is a beautiful song. She says: *'thanks to you we can now also play it.'* […]. The musicians leave the room. Once on the corridor, Madelief starts to cry and says she has to go to the bathroom. She hands over her flute. Jonas also hands over his instrument and goes after Madelief. Roy, Caroline and [the mediator] stay behind and remain silent. What just happened needs processing.

As described above, the musicians were deeply moved by the musical goodbye to Mrs. Mulder who was now going to home to die. Doctor-in-training Caroline seemed visibly touched by the moment, as well. However, the nurses of the ward refrained from partaking in the situation. Later in an interview, nurse Jasmine reflected (from Smilde et al., 2019, p. 101)[124]:

> *Yes, I gave care to the woman, but I was not there in the moment when [the musicians] played for her, and then, I thought 'What a pity.' However, I understood that it was a very emotional moment and I thought, 'Well, then I could not have held away the tears.' That is not really terrible, but as one has other patients to care for, it can be.*

In this reflection, the tension between the nurses' sense of professional identity and emotions is emphasised. Ten Hoeve (2018) reminds that, especially novice nurses, can feel significant distress when exposed to emotionally heavy incidents, such as death (p. 130). So, it can be seen that engaging in one's work with the whole personhood (see also Youngson, 2012) can be complicated when it comes to dealing with the intense emotions that live

124 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 101).

music evokes.

In the MiMiC practice in particular, restricting oneself from becoming emotional or even removing oneself from the musical situation altogether, appeared to be, at times, a necessary means of self-protection. There seemed to be, however, ways to deal with the profound emotions that some of the musical moments evoked. Coordinating nurse Jessica suggested in an interview:

> *Then you step outside for a moment and distance yourself. And then, the feeling goes away and you think: 'Okay, I'm fine now.' It is just that little moment where you think: 'Yes I am feeling something, too. Yes.' I think that that's allowed. As long as you don't weight it on your patients. You just simply cannot.*

Here, strategies for balancing the emotions and the *professional habitus* (Goffman, 1959/1990) are reflected upon. Distancing oneself by stepping out of the room could offer a way to protect, or perhaps regain a sense of perceived professionality, which could also be interpreted as a form of compassion; wanting to give the absolute best possible care to the patient. This interpretation is in line with Ten Hoeve's (2018) understanding of nurses' professional identity, and how it is tightly tied to the values and beliefs of what is good nursing and caring (p. 39, see section 3.2.3). These values and beliefs guide the nurses' interactions with their patients (ibid.).

Making sense of this tension and finding ways to *be with* (see Benner, 1984/2001) the patient, in spite of the emotional complexity, was especially clear in Jessica's following reflection. From Smilde et al. (2019, pp. 99-100)[125]:

> *We are people as well, of course, and we feel a lot about things, as well... And I think it is a good thing to acknowledge that. As I said before, one piece of music really moved me. And then you think, 'Why does this move me? Oh yes, that's why.' You are a human being. It's allowed. And sometimes it's like, 'Darn, does this have to be now?' But for me that's okay. I allow myself to feel that, as long as I do not weigh my patients down with it, in the sense of 'I'm so sad right now.' [...] But you can say to someone 'This is really difficult for me now.' Sometimes you talk about it, and things surface of which you think: 'How should I deal with this?' And then you can say 'Gosh, I don't really know how to respond right now. This is difficult for me, too.'*

Although the interviewees clearly felt a strong emotional resonance with their patients, wanted to share the musical situations with their patients, and felt that their own emotions had a legitimate place in their professional life, coping with the emotions while giving care was not simple. Here, the need for *self-compassion* (see Gilbert & Choden, 2013; Neff, 2015) was clear. In her reflection, Jessica was making sense of her emotions and of letting them surface. Jessica's reflection emphasises an acknowledgement of her struggle to cope with her emotions in the musical situation, followed by a self-compassionate allowance to feel said emotions. These processes are important elements of self-compassion (see Neff, 2015 in section 3.3.3.3). As an outcome, Jessica appeared to find a way of dealing with the emotions together with the patient.

125 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 99-100).

Finally, the observations and collected narrative accounts suggested that there were similarities between allowing oneself to participate in the music sessions (see section 5.1.3.1) and allowing oneself to become emotional during the processes taking place in the sessions. Especially when it came to sadness or sorrow, there appeared to be a tension between wanting to give person-centred care by *being a fellow human* (see also Van Heijst, 2005 in section 3.3.3.3) to the patient, as was prominent in Jessica's reflection, and aiming to keep one's professional front intact (after Goffman, 1959/1990) by protecting oneself from intense emotions.

5.2.5.4. Compassion: display of kindness and care through music-making

Compassionate care means a wholesome and relationship-focused approach to giving care, which involves an active pursuit for acts of kindness to relieve 'the other's' suffering (see also Ricard, 2013; Gilbert & Choden, 2013 in section 3.3.3.1). Earlier in this dissertation, it was described how the healthcare professionals' musical participation could open new possibilities for an active display of compassion, including hand-holding, helping someone to make music, handing a tissue to patients or residents when they get emotional, or joining the music-making to support the other (see section 5.1.4.2).

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Earlier, a moment when the musicians asked nurse Amanda to wish something for her patients, Mr. Smit and Mr. Kleine, through the music was described (see section 5.2.3.2). Amanda wished the men for relaxation, as she knew that they were going through a difficult period of recovery. It can be seen that Amanda's wish was an act of compassion, as she aimed to wish for the patients what she knew could help them feel better. Amanda reflected upon how she was able to display compassionate care as a nurse to her patients through music in Smilde et al. (2019, p. 42)[126]:

> *By chance, we had previously talked about that they were very tense and actually, a little fed up with being ill, that it all takes so long, that you have to give up so much for it. And, well yes, then I said: 'I would like to give you some more relaxation.' Then, [the musicians] made an improvisation on that.*

Here, the potential of participatory music for integrating with and supporting compassionate care delivery is clear. Amanda's account is reinforced by similar narrations of various healthcare professionals. For example, doctor-in-training Caroline reflected in an interview:

> *[…] it is also really beautiful if you can say in the patient's presence: 'I really wish you the best', or 'I really hope that you will be well.' And that there can then be a piece of music again. Yes, I find that just really beautiful.*

126 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 42).

Again, the value of person-centred music-making as a support for presence as *being* instead of *doing* in the care relationship is highlighted (see Benner, 1984/2001 in section 3.3.3.3).

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Similarly, in the Music and Dementia practice, where the musical interactions happened in the circle (see section 2.1.2), experiencing profound emotional resonance with the residents during the music sessions had the potential to help caregivers display more compassionate care to the residents outside the session time – even when the caregivers were under time pressure. Caregiver Eleanor explained in an interview:

> *It helps me if I see a resident in the circle … [because] very often it is just busy [at work]. You are rushing on the ward, you have things to do, many things must happen. And then, sometimes it just happens that you can pay attention to the person as a person. For example, what I really like is that I sometimes see [residents who are involved in the music project], and then my thoughts automatically go back to what the music sessions were like. And then, it is just more like: 'Ah, hello!' Unlike: 'I am busy now!' […] It comes from sharing so much emotion during those sessions, so then you become more aware of how you handle [those situations].*

Eleanor's reflection is in line with the articulated goals and values of the Music for Life (see section 2.1.1) and Music and Dementia practices (see section 2.3.2.), as she seems to be describing a shift from task-centredness to person-centredness in her work. This shift is catalysed by the shared emotional experiences of the music-making, and it emphasises the potential of the participatory music practice to evoke compassionate presence (see Van Heijst, 2005) as a small cultural change in the nursing home care.

5.2.5.5. Sympathetic joy: rejoicing for the musical flourishing of 'the other'

As explained in section 5.2.2, the healthcare professionals' experiencing (after Dewey, 1938/2015 in section 3.1) of the participatory music practices seemed profoundly interconnected with their perceptions of their patients or residents' musical experiences. Especially when it came to making sense of the value of the music practices, the healthcare professionals seemed impacted by the immense sympathetic joy (see also Jormsri et al., 2005; Ricard, 2013 in section 3.3.3.2.), which they felt for the patients or residents' positive experiences during the music sessions.

Sympathetic joy was expressed, to a great extent, by the healthcare professionals in both the MiMiC and Music and Dementia practices in interviews and group discussions. Most typically, the healthcare professionals' positive judgement of the music practices was connected to the feeling of joy for the perceived benefits of music-making for the patients and residents. For example, nurse Miranda described in an interview (from Smilde et al., 2019, pp. 107-108)[127]:

127 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 107-108).

So, I really think that [the music sessions bring me] emotions, a bit of calmness, and well, yes, I could above all enjoy that the patients were enjoying it themselves. I found it the most beautiful thing to see […].

In line with Jormsri et al. (2005) and Ricard (2013), the rejoicing for 'the other's' well-being gives the healthcare professionals a deep feeling of fulfilment and joy. In Mead's (1934/2015) terms, sympathetic joy seems to be connected to the social mechanism of looking 'through the eyes of the other' (see section 3.2.3). In both observed music practices, the healthcare professionals' sympathetic joy was strongly present in their reflections; they frequently explained that seeing the patients or residents enjoy the music sessions evoked immensely positive emotions.

In many accounts, the expressed sympathetic joy was also connected to the healthcare professionals' perception of their patients' or residents' flourishing in the music sessions. Activity leader Jane reflected in an interview:

I find it just really beautiful what happens there [in the circle]. Sometimes you become a bit emotional from thinking: 'The people who are sitting there are very ill' and then, you can see them still so happy. Because that is it! You know? If someone can get such a huge smile on their face, play an instrument or is brought into a complete 'trance' because someone plays the harp, that is wonderful, since you know how ill these people are. […] And you know that they will eventually die. So, if you can offer them something beautiful in that moment, then it is just lovely. When I see that, I become quite happy.

In line with Seligman (2011) (see section 3.3.2), Jane's reflection emphasises meaningfulness and positive emotions, which are central to flourishing in the present moment – hence components of well-being.

The analysis suggests that, in both care contexts, the core of what evoked such a strong sympathetic joy in the healthcare professionals lay in the contrast of the patients' and residents' vulnerability due to their condition, and the *kairotic moments* (see Sipiora, 2012) of observed musical flourishing. These moments of flourishing and the evoked experiences of sympathetic joy could also help to further develop the care relationship between the healthcare professionals and patients or residents. For example, through the shared musical interactions between coordinating nurse Werner and Mr. Boekman (see section 5.2.4.2), Werner gained new awareness of his prejudices towards his patient, as the musical interactions showed him that his *set of assumptions* (see Benner, 1984/2001 in section 3.2.3) about Mr. Boekman were wrong. Later in an interview, Werner reflected upon what the new knowing brought to his work:

Werner: *I can't say, 'I have more pleasure in my work', because I always enjoy working, but I do it in a different way [during the music sessions]. I am more carefree.*

Q: *Could you describe that a bit more?*

Werner: *Well, you also see patients flourishing, it is also more pleasant to take care of them.It is also quite touching to see the patients flourishing.*

Q: *And what can that bring about?*

Werner: *A lot of positivity, and I think that it has a great influence on the recovery of the people.*

Not only was Werner's perception of his patients' flourishing through the musical interactions emotionally engaging, but these emotions, which could be interpreted as sympathetic joy, appeared to also increase his positive emotionality and job satisfaction. It is important to recognise the interconnectivity of Werner's accounts in terms of his own narrated-upon increase of positive emotionality at work and the perceived benefits of the music sessions for the patients' recovery process.

It appears that the healthcare professionals' emotional fulfilment, as brought upon by the experiences of sympathetic joy, could support their flourishing at work, as well (see section 3.3.3). Coordinating nurse Jessica detailed in an interview the active feelings of sympathetic joy in a moment of music-making:

> *As I said, it's very nice to hear [the improvisations]. And then, [I wonder]: 'Do I recognise [the theme] in it? The theme that the patient wants to recognise.' That is what makes it so much fun to listen to, and especially also to see the patients' faces: 'How do those people enjoy themselves?' And I think that is fulfilling for the healthcare professionals, you could say. Just like: 'What do I recognise in this [improvisation]?' And 'Is the patient really carried away from their bed? Has [the patient] been transported [by the music]?' And 'Are they now really experiencing the grasslands of Drenthe[128]?'*

Jessica's narration shows clearly that the nurses' sympathetic joy is not only connected to the patients' responses to person-centred musical approaches, but also to the creative processes of the nurses' own musical imagining (see also DeNora, 2000; Turino, 2008; Hesmondhalgh, 2013 in sections 3.1.6; 5.2.3.1) in the moment of the music-making. These relational processes, as described by Jessica and Werner, seem relevant for creating feelings of fulfillment for the nurses' working life.

5.2.5.6. Feelings of appreciation, respect and gratitude towards the musicians

It has previously been explained that healthcare professionals experienced the musicians' ways of communicating and interacting as kind, friendly and respectful (see section 5.2.4.4). Furthermore, the healthcare professionals *felt* deep appreciation, respect and gratitude towards the musicians' professional presence and approaches in the music sessions. The musicians' perceived sincerity and full-hearted dedication to their professional values of person-centredness were especially appreciated by the healthcare professionals.

The nurses' appreciation towards the musicians was accompanied by gratitude, something which was captured in a moment with Mrs. Mulder (see section 5.2.5.3). Mrs. Mulder was a dying woman for whom the musicians arranged *Angels* by Robbie Williams on her last day at the hospital, as it had been an important song for her and her grandson. Nurse Jasmine reflected:

128 Drenthe is a province in the region of Groningen in the Northern Netherlands.

Well, I thought it was really beautiful. It is very special that right then, there were musicians and that they could play for the woman. And also… Because it was a request from the day before, it had to be rehearsed. […] So, I knew that it was a very meaningful moment and we talked about it among the colleagues. Also, [how valuable it was] that the musicians could play this song to the woman.

This compassionate account highlights the grateful appreciation towards the musicians' dedication for arranging and performing the piece for Mrs. Mulder at the end of her life. According to Ricard (2013), gratitude is a significant element of well-being at work as it feeds into positive relationships that can increase a sense of belonging and diminish negativity in the work community (see also Compton & Hoffman, 2013; Redelinghuys & Rothmann, 2018 in section 3.3.3)

Furthermore, the healthcare professionals' appreciation and respect towards the musicians' professional skills were particularly focused on the musicians' ability to improvise music and play together seamlessly. For example, coordinating nurse Gina described in an interview:

First, [the musicians can play] music by a specific composer, but they can also improvise [new] pieces, where you can really hear [the patient's musical idea]. I think that is wonderful and I have a lot of respect for it.

Similarly, coordinating nurse Jessica reflected (from Smilde et al., 2019, p. 112)[129]:

I really admire that they come up with [the improvisations]. […] I don't know how they do it, but I really think it's quite a skill.

In addition, the musicians' ability to work together as an ensemble while improvising evoked respect and admiration in the healthcare professionals. In the Music and Dementia practice, activity leader Jane explained:

I think it is very impressive, and because they are improvising everything, the music comes together wonderfully. I think that is really impressive, because naturally there is no time to rehearse [in advance] and yet, [the musicians] are able to, without rehearsing, play together.

The healthcare professionals' respect towards the musicians' ensemble skills went beyond the creation of the improvised pieces of music. For example, nurse Merel reflected in an interview upon how the musicians' collaboration as a team had a seamless unspoken quality. Merel explained (from Smilde et al., 2019, p. 102)[130]:

[The musicians] are good at tuning in with each other. I find it beautiful to see. With improvisations as well. That they walked into room in a given moment, it was a perfect timing.

129 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 112).

130 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 102).

That was a very beautiful transition. […] …it happens so effortlessly. Not forced or something.

Similarly, nurse Miranda told in an interview:

I pay attention to the teamwork of the musicians; how it works.

The healthcare professionals' respect for and interest in the musicians' teamwork were centred around the musicians' non-verbal communication during the music-making, e.g. eye contact and body language. Nurse Helen reflected in an interview:

Well, they have quite a lot of eye contact with the patients, but also with each other as musicians.

The appreciation of non-verbal communication, based largely on eye contact, was discussed further in a group discussion after a MiMiC project:

Ava: *Yes, [the music] enters me…*

Cecilia: *Well, I really find it beautiful to see [the musicians] playing. That gives it an extra-dimension besides hearing them [play].*

Ava: *You feel it, too.*

Cecilia: *And the musicians look at you, too. Eye contact is important.*

Roos: *Yes, exactly. They are looking at you. Also, [they are] communicating with each other about the story that they will go along with. Yes, this concept has a lot of added value to our patients.*

Ava: *Yes, I felt that it was also really beautiful to see what happens between the musicians. How they negotiate things among each other and how they know with the help of just short signals where the music continue to go. Wonderful.*

The musicians' observed non-verbal communication carried the mutual signals of music-making, but also, seemed to communicate their enjoyment of the process, which resonated positively with the healthcare professionals' emotional responses to the music-making. Nurse Jasmine continued to explain in the group discussion:

I think it is wonderful that the musicians also seem to be enjoying their music-making. You know? Their entire body language expresses this. That is just so beautiful to see, that they are really enjoying it.

Watching the musicians enjoy their engagement in the music-making with the patients and residents reinforced the healthcare professionals' perceptions of the musicians' genuine intentions. Activity leader Jane reflected in an interview:

Yes, I think it is very special… you notice that [the musicians] connect to [the residents]. They make sure that they don't play out of a sense of duty: 'Well, I play just for an hour and then leave again.'

Feelings of appreciation and respect are significant elements of positive emotionality within a work community (see Compton & Hoffman, 2013; Ricard, 2013 in section 3.3.3). It has been argued that a community of practice can emerge slowly between the musicians and the healthcare professionals (see section 5.1.4). Therefore, the feelings of appreciation and respect can be considered as relevant facilitating factors for the development of an interprofessional community of practice (see also Lave & Wenger, 1991 in section 3.2.2).

5.3. Learning benefits: Reflected upon articulation of new knowing

The third core category of this research is *Learning benefits*. In this final core category, the identified aspects of learning, which can be considered as support to the care routines and work culture of healthcare professionals, are analysed. These aspects are *new value-based awareness* (section 5.3.2), *new knowing and understanding of care* (section 5.3.3), and *experienced support and increase of work resources* (section 5.3.4).

5.3.1. Learning through reflection upon experiencing: first analytical remarks

It has been argued and exemplified in the previous sections of the analysis on *Participation* (see section 5.1) and *Experience* (see section 5.2) that participation in the music practices fosters healthcare professionals' experiential learning. The experiences that participation in the music practices stimulates are characterised by atmospheric, communicational and emotional qualities. When it comes to healthcare professionals' experiential learning in the MiMiC and Music and Dementia practices, it seems that four all-encompassing analytical remarks can be made about the data:

1. REFLECTION LEADING TO AN AWARENESS OF CHANGE

Reflection appears to be crucial for identifying a change in one's perspective or attitude. For example, through reflecting on his new understanding of his patient, Mr. Boekman (see again section 5.2.4.2), coordinating nurse Werner seemed able to acknowledge and articulate what he had learned through the shared musical interactions. Werner reflected in an interview (from Smilde et al., 2019, pp. 49-50)[131]:

> *I draw the conclusion that it is why he was so grumpy: 'he could not release his emotions and his story', I think. The man was just homesick for his farm. He just missed his cattle. And that emerged now, [through] the music. And before then, he did not speak about it. Then, he was just only angry and grumpy and cursing, and so on. Nothing else came out [of him]. And now through the music, he became a completely different person. So, I thought that is [the most important thing] learned.*

Werner's reflection emphasises the connection between his experiential insights emerging from the musical interactions and his articulated new knowing. This interpretation of Werner's reflected-upon experiences and learning processes reminds of Dewey's (1916/2009) words: "When we reflect upon an experience instead of just having it, we inevitably distinguish between our own attitude and the objects toward which we sustain the attitude" (p. 130).

2. SOME OF THE NEW KNOWING REMAINS IMPLICIT

In the analysis on the healthcare professionals' experiencing of the music practices (see

131 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, pp. 49-50).

section 5.2), it seems that for many interviewees, putting their experiences into words – even when describing the meaning of a seemingly significant or deeply emotional experience – was difficult. For example, caregiver Theresa reflected in an interview:

> *I can only describe it as 'special'. I say: 'words sometimes fall short.' […] It is difficult to put the meaning into words. It is a feeling of togetherness. […] It is pure feeling. It is like being in another world.*

As demonstrated in Theresa's account, when it came to attempting to explain the meaning of one's experiences in the music practices, healthcare professionals sometimes acknowledged their inability to find the words to describe them. Dewey's (1938/2015) concepts of 'knowing that' and 'knowing how' (see section 3.1.3) seem relevant here, as experiential learning embraces the interface of implicit and explicit knowing.

3. THE ACCUMULATION OF EXPERIENCES INTO NEW KNOWING

The cumulative development of new knowing from the very first moments of familiarisation to the end of a music project seemed apparent in the narrative data. For example, coordinating Werner reflected in an interview after a MiMiC project:

> *I have seen a lot and I have heard a lot. […] I found it striking that a large group of patients were against it at the beginning, but when the music started and they could hear it, they became enthusiastic about the music. I saw the same thing happen with the colleagues. Of course, [the musicians] were here now for the third time, and the first time was about getting to know each other. The more often [the musicians] visited, the more enthusiastic the colleagues became.*

Werner's description of the social changes that happened in a processual way seem very much in line with Dewey's (1938/2015) principle of continuity of experiencing (see section 3.1.2).

4. REFLECTING BY LOOKING THROUGH THE EYES OF 'THE OTHER'

The healthcare professionals did not seem to reflect upon their learning experiences of the music practices only from their own perspective, but also from the perspective of the patients and residents (see section 5.2.2). For example, coordinating nurse Jessica reflected:

> *I think that [the music] brings a lot of energy and for the patients, energy and strength. As in: 'I'm going to do this. I'll get out of the bed in a moment.' And we are like: 'Okay, we are good to go! Bring it on, we are good to go on a bit longer.'*

Once more, Jessica's meaning-making can be interpreted in Mead's (1934/2015) terms as 'looking through the eyes of the other.' In many accounts, the interviewees narrated their learning processes and their new knowing from two perspectives simultaneously, as Jessica's appears to do in her reflection above.

5.3.2. New value-based awareness

5.3.2.1. Meaning-making of the value of the music practices

In terms of the healthcare professionals' learning benefits of the music practices, *new value-based awareness* seemed to be a fundamental aspect of the experienced positive social changes within the care relationship and care delivery. The healthcare professionals' perceived value of the music practices seemed to be focused on the evoked social and emotional responses between the healthcare professionals and the patients or residents. Nurse Aurora explained in an interview:

> *The room feels smaller, you get closer to each other. […] I value the patient contact a lot, so I think that [the music sessions support the care].*

Similarly, in the Music and Dementia practice, activity leader Jane summed in a group discussion:

> *[…] So, that intimacy; that live music; interaction; that eye contact in the circle. Not [being seated] in rows, but in a circle. It all contributes to something starting to grow.*

It can be noticed that the value attached to the music-making seemed to be mainly focused on what the music practices could contribute to the care rather than on the perceived aesthetic qualities of the music. For example, coordinating nurse Julia explained in an interview, when asked what the MiMiC practice meant for her work:

> *The well-being of the patients is extremely important to us. If a moment [of music-making] can help [the patients] through a difficult situation or that they can think about something else than being in the hospital, then you have achieved a lot.*

Similarly, caregiver Theresa, who was making sense of the value of the Music and Dementia practice for her work in a nursing home, reflected:

> *I think that the calmness [of the music-making] is so important because it gives [the residents] an opportunity to participate; space to respond. […] There are enough musical activity days, where a musician comes to perform. Then you listen or you smile a little or you clap. But now, [the residents] are part of [the music-making]. They are equal. It is not: 'The musician and me.' No. It is: 'Us.' Do you understand? That makes it special, I think.*

The healthcare professionals' narrations above emphasise the ethical principles of community music-making (see also Higgins, 2008, 2012; Lines, 2018; Matarasso, 2019). Furthermore, the pragmatic view of the value of musical experiences is highlighted in the narrative accounts, as the situational needs of the participants within the context of the activity are framing the described processes of *growth* (see also Dewey, 1938/2015 in section 3.1.2) Hence, the value of musical experiencing, according to pragmatism, lies in its potential to evoke change that can broaden the participants' horizons of meaning and thus,

reconstruct the culture of the community (see Väkevä & Westerlund, 2009, p. 97 in section 3.1.7).

Through musical participation, coordinating nurse Julia seems to have become aware that even short moments of 'special attention' to the patient could be enough to 'achieve' an enhancement in the patient's experience of well-being. Jane describes the social changes in the Music and Dementia circle as growth. Similarly, Theresa's new value-based awareness of creating moments of equality in the circle can be viewed as broadening her horizons on what musical participation can mean for the care community and the culture of the nursing home.

5.3.2.2. The value of person-centred music-making supporting care

In particular, the analysis on the observed musical situation and the healthcare professionals' narrative accounts suggests that person-centred music-making can support the achievement of person-centred care, especially when the healthcare professionals' job resources are strained.

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It seems that through musical interactions, person-centred care values could also be reinforced in action. Coordinating nurse Jessica explained in an interview (from Smilde et al., 2019, p. 98)[132]:

> *And even if as nurses, we don't have the time to join the patients while they're listening, you do think: 'Who's at the patient's bedside?' And that is a really good thing as well.*

Jessica continued:

> *[…] the patient indicates what he or she wants to hear and then, [the musicians] make up something on the spot. So, at that moment, the patient is the leader. The patient says: 'Jump', and the musicians ask: 'How high?' That also gives a sense of leadership; that [the patients] are 'running the show', and I think that it is very good for them. They finally get to decide something. That is, I think, the greatest advantage of the improvisations, that at that moment, the patient is in charge; that they get to choose.*

Here, the value of kairotic moments in the music-making are emphasised once more (see section 5.2.3.2). The nurses' acknowledged value of person-centred music-making seems to be connected to aspects of personal recognition, as Jessica's reflection above suggests.

It can, furthermore, be interpreted that the recognised value of person-centred music-making feeds into the healthcare professionals' experiences of sympathetic joy towards the patients or residents' meaningful musical engagement (see section 5.2.5.5). Coordinating nurse Gina reflects in an interview (from Smilde et al., 2019, p. 109)[133]:

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132 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 98).

133 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019,

> *A bit of deepening, broadening and enriching, in the first place. In every sense. […] I like it very much, but especially because I see that patients benefit greatly from it and that they get revived from it, in general. There is really something about it. Real added value.*

The rejoicing for the other, as narrated by Gina above, seems significant for the healthcare professionals' job satisfaction and resources (see section 3.3.3.5). The reflections on the music practices highlight the value of time, presence and intimacy within the social interaction, which are known factors supporting healthcare professionals' well-being at work (see Youngson, 2012; Lases, 2017 in section 3.3.3).

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The personal recognition of the residents seemed equally important for the caregivers in the nursing home care context, where the need for supporting the residents' sense of identity and personhood is indisputable (see also Kitwood, 1997, section 1.2). Caregiver Theresa reflected:

> *Through the music and the singing, the welcome song and that [the residents] are greeted by their names, it means a lot to them. That they really get the feeling: 'I matter; I belong; they know me and that is nice.' And naturally, there are cards with the participants' names in front of their seats. They know: 'The musicians are expecting me.' So, I think that it is the really important, indeed. The recognition. Then, you see slowly that they begin to feel safe; accept instruments, sing along. I do see a whole process in it.*

Recognising the person behind the condition is a cornerstone of person-centred care. Thus, it can be interpreted that the values of person-centred music-making (see section 3.2.5) resonate with the caregivers' professional values of the care.

5.3.2.3. Reinforcing the value of compassionate care through music

It has been argued previously that there was a strong interconnectedness between the healthcare professionals' perceived value of their patients or residents' musical experiences, and their own judgement of the merit of the music practice for themselves. Often, this interconnectedness seemed to be rooted in an emotional resonance with and empathy towards one's patient. Coordinating nurse Werner narrated:

> *You cannot go along with all emotions, only with certain emotions. With one patient I am more touched than with another. And I find it very beautiful to see that people show their emotions [during the music sessions]. But that has to do with my own emotions: I used to be much more closed up and did not dare to show my emotions quickly. I learned that also through experience: 'let your emotions go, they are allowed to be seen by another persons'. And music can release a lot of emotions.*

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p. 109).

The empathic feelings towards the persons in care could evolve into an active form of compassion (see also Ricard, 2013 in section 3.3.3.1) through the musical interactions (see section 5.2.5.4). For example, when nurse Amanda was asked to wish something for her patients in a MiMiC session, she got the opportunity to give compassionate care through the musical piece (see section 5.2.5.4). Finding ways to give compassionate care through music seemed imperative in the short-term care context of the hospital. Coordinating nurse Jessica explained:

> *It can provide an opening, like 'How does it make you feel?' 'What's going on?' 'Is there anything I can do for you?' 'Or should we just sit here together?' Patients are here only for a very short time, really. Some of them are here for two or three weeks. And that is relatively short because during that period they are very ill and have no energy to talk extensively about that kind of thing. But the music, it brings emotions to the surface. And it also helps us to deal with things.*

Based on Jessica's statement, it can be argued that person-centred music-making can have value for supporting and strengthening the development of compassionate care relationships. Nurse Josephine described in an interview:

> *I became really happy when [the musicians] were here […] Happy that I was brought closer to the patient.*

The benefits of the reinforced compassionate encounters with the patients through music can contribute to the rediscovery of intersubjectivity in the hospital care (see also Cohen-Salmon, n.d., p. 3 in section 2.1.2). Doctor-in-training Caroline confirmed this view in an interview:

> *It adds a lot to the bond you have with a patient.*

The support for intersubjectivity in the hospital care seems highly valuable for creating small changes to the culture of care. Social worker Doris anticipated the future in an interview:

> *Having live music regularly would really soften up [a ward]. Especially a surgical ward, [where] the workload is so heavy.*

5.3.2.4. Awareness of the value of collaboration: new interprofessional horizons

Through the process of this research, it has become clear that the healthcare professionals in both care contexts have highly developed professional identities. In line with Ten Hoeve, (2018 in section 3.2.3), the collective values of care are reflected back in the healthcare professionals' interactions with the musicians and patients or residents. Especially when it comes to the value of collaboration in the work teams, it appears that the collegial relationships are a significant resource for membership, belonging and support. Coordinating nurse Hannah described the importance of a strong work team in a group discussion:

We are a team that is tuned-in to each other. Everyone helps each other, nobody is left fending for themselves. It really is a very good team that we have.

It has been shown previously that the collegial support of *old-timers* for *newcomers* (see also Lave & Wenger, 1991) to join the participatory music sessions was important for facilitating experiential learning (see section 5.1.4). On many occasions, the support and encouragement for participation in the music sessions of those colleagues who were taking the role of 'old-timers' seemed instrumental for the newcomers' change of attitude about the music practice or about participating in it. For example, in the case of activity leader Jane (see section 5.1.3.1), being supported by her colleagues to participate in the circle led her to understand that *daring* was the most significant challenge for her in regard to her involvement in the music project.

Furthermore, it has been proposed that through the participatory processes of the music practices, communities of practice could slowly emerge between the healthcare professionals and the musicians (see section 5.1.4.1). The development of the communities of practice between the two groups of professionals could also lead to a new value-based awareness of the merits of interprofessional collaboration in care. For example, in the case of wound care for Mr. Smit (see section 5.1.4.1), the nurses explained clearly that the collaboration with the musicians was beneficial not only for the patient's well-being but also for the nurses' (ibid).

When it comes to a new awareness of the interprofessional collaboration with the musicians, the healthcare professionals seemed to recognise the professional values of the specially trained musicians. Coordinating nurse Hannah and nurse Merel reflected in a group discussion:

Hannah: *[…] I hope very much [the music practice] remains here. I find it very beautiful, but I do think that not every musician can do this work. I think that not every person is suitable for it. You see also that [the practice] means a lot to the musicians, too. The trio that is here now, they know exactly what they have to do. I think that not everyone can do that.*

Merel: *Yes, it is very good, but it is also so because of how [the musicians] are. [They] fit right in. […] You must be a good judge of character.*

In Hannah and Merel's reflections, it can be interpreted that the values of professional and interpersonal qualities are intrinsically connected with belonging to the emerging community of practice, as Merel says: "*[The musicians] fit right in*." Here, Wenger's (1998) concept of '*learning as belonging*' as a component of a community of practice seems relevant (see section 3.2.2).

5.3.3. New knowing and understanding of care, music and communication

5.3.3.1. Professional reflection on the ways of working and the culture of the care

The accumulated experiences of the music practices could stimulate critical reflection on one's ways of working, as well as the culture of care in one's workplace. When coordinating nurse Werner looked back on his learning in the MiMiC practice in regard to his relationship with Mr. Boekman (see again section 5.2.4.2), Werner's critical reflection led him to reconsider the culture of his ward; judging the patients by their behaviour with a set of assumptions (after Benner, 1984/2001 in 3.2.3) rather than attempting to look deeper into the patient's personhood. Werner reflected in Smilde et al., (2019, pp. 50-51):

> *To continue [asking the patient] in this manner: 'Well, yes, what is the reason you are so grumpy? Is there something wrong?' You continue to ask more about it. There is always a reason behind it. That is what I have learnt. We often approach it like: 'It is probably someone's character'. But that is not always it. Just look: If you have experienced something terrible, or if you are really homesick, then you can also react quite differently. Then you are different from who you usually are. I also notice it within myself. I am always very open, but if I experience something terrible, I can also retreat into my shell.*

It seemed that through reflecting on his experiences in the music sessions, Werner was able to look critically on his and his colleagues' approaches to patients who were behaving in a negative way. Werner eventually became aware of the nurses' attitude towards these patients and of a need to approach them with more compassion. Thus, Werner' critical reflection subsequently brought about new knowing that challenged his professional way of thinking. Dewey (1938/2015) points out that in critical reflection, the agreeableness or disagreeableness of the new experience, in relation to one's previous knowledge, is central to creating change (see section 3.1.4).

On the other hand, the agreeableness of the new experience (after Dewey, 1938/2015) could also reinforce the healthcare professionals' earlier understandings about the care. For example, caregiver Loes reflected upon how she was reminded of aspects of engagement that she already was aware of through participation in the music sessions. Loes explained:

> *Yes, I think that it is quite an enrichment that we now experience this together. Just by experiencing it, we learn a lot from it. This is an experience that you will take with you for the rest of your career, I think. And we are reminded that the music just can do a lot for the [residents]. Although we already knew that.*

Furthermore, gaining new understandings of the interconnectedness of one's own mood and composure and the residents' behaviour appeared to provide a new professional perspective for caregivers in the nursing home. Reconstructed from the fieldnotes:

> It is the second session of the project and it is caregiver Mathilde's first time in the circle. Mathilde is seated next to Mrs. Braam and holds a seed rattle in the air for the woman to play. Mrs. Braam takes it into her own hands, but shortly gives back to Mathilde. Mrs. Braam seems

wary of the instrument; the instrument is an unfamiliar looking cluster of strange dried seeds. So, workshop leader Roy comes closer to the Mrs. Braam and begins to sing to her to calm her down. Roy is mirroring her expressions and slight movements at a very close proximity, until Mrs. Braam suddenly bursts into singing. It is now clear that she would much rather sing than play the seed rattle. Mathilde is leaning closer to observe the interaction between Roy and Mrs. Braam. When the tender moment of singing comes to an end, Mathilde remains leaned towards Mrs. Braam as to accompany her all the way until the end of her piece.

It is Mathilde's turn to play the seed rattle now. As she starts, Mrs. Braam, who seems proud of her beautiful vocal piece that just ended, cannot help but keep talking to Mathilde about it, so Mathilde balances her attention between the woman and Roy, who has caught the pulse of Mathilde's seed rattling and begins to intensify the rhythm on his cello. Mrs. Braam starts to sing out loud to the music, while Mathilde plays. It becomes a lively rhythmical piece that is now shared by Mathilde, Mrs. Braam and Roy.

On the second round of the passing instruments activity, Roy proposes Mrs. Braam to conduct with a baton. She is happy to conduct *but only* with Mathilde. Mrs. Braam takes the baton slowly and warily, so Mathilde asks her: *'Are you ready?'* Mrs. Braam nods and starts to conduct, while Mathilde helps her to move the baton in the air. Roy comes close to face the two women with his cello. When the piece ends, Mrs. Braam laughs freely, and Roy pays her a compliment: '*It was beautiful*.'

On the last session of the project, the 'framing piece' starts. Mrs. Braam and Mathilde sit next to each other again. While they sing along to the melody, they exchange warm smiles and glances with each other and hold hands. It seems as if they are in an unbreakable unity in their music-making. Soon, the 'welcome song' starts, and Mathilde sings along to it with Mrs. Braam by her side. When Roy greets Mrs. Braam, she first glances at Mathilde for an affirmation before turning back towards Roy for a nod at him.

During the passing instrument activity, Mrs. Braam and Mathilde are offered to play the bongos, and again, Mrs. Braam agrees to play the drums together with her. This is not surprising, since they have been inseparable since the beginning of the session. Roy hands the bongos, and the women begin to play. They sing while playing, and Mrs. Braam initiates an intense eye contact with Roy when singing. It causes her to lose her attention of the drumming for a moment, and so, she stops abruptly playing. Mrs. Braam starts to talk to Roy, as she is now distracted from the music-making, but Mathilde gently re-engages her in the music-making by a touch and a smile. The women carry on gazing at each other again, smiling, singing and playing; an interaction full of warmth.

In this reconstructed description, the potential of the musical interactions for catalysing compassionate contact and person-centredness in the care relationship seems strong. The description fits to the already interpreted perspectives on the value of co-participation (see Billett, 2007 in section 3.2.1; section 5.1.4.2) and compassionate care (Ricard, 2013; Gilbert & Choden, 2013) through music (see section 5.2.4.4). Caregiver Mathilde described her experience in the circle with Mrs. Braam later in an interview:

> *Well, Mrs. Braam likes singing very much. I really enjoy singing, and I notice that if I participate, she will also participate.*

Mathilde's realisation of the interconnectedness of her participation and Mrs. Braam's was one that had clear professional relevance for her work. Caregiver Wilma made a similar remark in a group discussion:

> *That is what I claim; finding peace within yourself. If you radiate peacefulness, the resident will also be calm. If you are going to be very hyper, the resident becomes hyper, too. They feel [what you feel]. That is the main idea that you learn here.*

Both Mathilde and Wilma's new understandings of the connectedness between their actions and interactions with their residents in the music sessions could likely support their care delivery at the nursing home, and thus, serve as a resource for their daily work.

5.3.3.2. Musicians modelling teamwork and new communicational approaches

Previously, it has been proposed that the healthcare professionals' observations of the musicians' interactions with patients and residents tended to evoke positive emotionality, because the healthcare professionals perceived the musicians as kind and friendly and felt respected and personally recognised by them (see section 5.2.4.4) Furthermore, the healthcare professionals seemed to respect the musicians' professional skills and values (see section 5.2.5.6). The musicians' implicit communication and decision-making in the musical situations in particular, were highlighted in the narrative accounts. For example, after a MiMiC session, nurse Merel detailed in an interview about her new knowing about teamwork that she developed through observing the musicians. From Smilde et al. (2019, p. 103)[134]:

> *I think how the [nurses] see [the musicians] with [the patients] …it is very friendly. And I think that the musicians also radiate a certain calmness that is agreeable also to observe and to listen to. Also, when they are playing, I find it wonderful to see how [the musicians] respond to one another. They look at each other, they take each other into account and then I think 'Yes, a lot of learning can be found in that', so to speak…I have said to our interns more than once: 'When [the musicians] are playing, look at how they look at each other and what they do then.' That is a learning moment. And then [the interns] pay attention to that. So, we can also do something more with how the musicians are responding to each other, so to speak.*

It seems that the musicians' communicational approaches could serve as a model for a new kind of teamwork for the community of nurses at the hospital. Thus, the musicians' professional competences could feed into the nurses' professional development. This interpretation fits with the notion of Väkevä & Westerlund (2009) that, when viewed from the perspective of pragmatism, the value of music is judged based on what kind of cultural change it can create. In Merel's example of meaning-making, her newly discovered potential of learning from the musicians' approach to teamwork prompted reconsiderations of the nurses' teamwork in the daily care of the hospital ward.

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134 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 103).

5.3.3.3. A new stance towards music at the workplace: changes of attitude and knowing

The healthcare professionals' narrative accounts suggested that the accumulation of experiences of the music practices created possibilities for changing one's attitude toward said practices. For example, in the Music and Dementia practice, where the framing piece was repeated ritually at the beginning and the end of each session (see section 2.3.2), the caregivers' attitude towards said piece, as well as their perceptions of its value, gradually changed. From a group discussion:

Ineke: *I really liked it.*

Wilma: *I liked it too. And it is also nice that it is so recognisable. The music at the beginning [of the session], I mean. Because, at first, I thought: 'Oh, not that music again.' But then, I thought: 'Oh no, that is actually quite recognisable for the [residents].' Because, we have heard it the previously, and they maybe recognise it: 'Oh yes. We have heard that before.'*

Wilma's change of attitude seemed, again, connected to her processes of meaning-making of what the framing piece *served* in the project and what it could offer to the residents (see also Väkevä & Westerlund, 2009). This kind of a meaning-making was especially significant when it came to the healthcare professionals' stance towards classical music in both care contexts. One of the most significant changes of attitude towards the music appeared to be the healthcare professionals' stance towards classical music. Nurse Merel described in an interview:

> *The first time […] I said: 'I do not like classical music', but since [the musicians] have visited, I sometimes put on some classical music on the radio. […] So, I have started to listen more [to classical music].*

Similarly, in a group discussion, coordinating nurse Hannah reflected:

> *I think that classical music touches a lot of emotions. It loosens people up. Perhaps it can be a helping tool for people who have a difficulty expressing themselves verbally. They feel that music makes it a little easier for them. So, something can be released. We notice that now. Afterwards, [the patients] talk about it.*

Having the music being played live and in close proximity seemed also instrumental for the change of the healthcare professionals' attitude towards the music. Caregiver Anna described in a group discussion:

> *When I heard [the musicians] play for the first time, I thought: 'Wow, I am sitting so close to it that I could almost touch it.' It is so beautiful.*

Also, in the MiMiC practice, the data suggest that there was significant growth in the nurses' appreciation of the music-making in the ward. From a group discussion transcript:

Q: *What kind of expectations did you have [about the project]?*

Merel: *I had expected that it would have less impact, but it has had much more impact than I had thought. And in a good way too, absolutely. It brings an enormous enrichment to us here.*

Hannah: *I have seen it now for four days, as I have been working for four days [during the project]. Then, you see some [patients] looking forward to it: 'Will [the musicians] soon come by?' I find that nice to hear; that it is really something that [the patients] can look forward to, I think.*

Furthermore, it appears that the change of attitude was particularly connected to the improvisations that were made specially for someone. Nurse Lena specified:

> *The improvised pieces are sometimes also very personal. If you, for example, ask for a colour or a landscape or something, then it is made personally for someone.*

Finally, in the nursing home context, the value of the music-making could be connected to concrete new ideas of applying music-making in care. Activity leader Jane reflected in an interview:

> *I certainly think that when you give care, you can sing more. Just singing, just using your voice; everyone eventually has an instrument at their disposal, and everyone can sing. Yes, I think that if the caregivers would sing more often, if they just hum a melody, [the residents] will join. […] We have received so many [musical] tools that we can continue using by ourselves.*

Jane's account shows a clear growth of confidence from when she barely dared to join in the circle (see section 5.1.3.1) to advocating singing at work, as "*everyone can sing*." The new 'tools' for employing music in nursing home care are later analysed in section 5.3.4.4. Unlike the nursing home context, where the practical value of the music-making was connected to new ideas of using music at work, nurses recognised music as an enriching, supportive and complementary element to the hospital care. Nurse Merel recalled in an interview:

> *I have learned that music can do a lot for people. Not only for the patient but also for the nurse or for the visitor. […] I think how it is used here in the hospital, [where] most of the people here in the ward get to hear bad news, it can bring a bit of a relief like: 'Oh, [the musicians] are coming again.' […] It gives me fulfilment.*

5.3.4. Experienced support for job resources

This section focuses on the analysis and interpretation of the healthcare professionals' experienced support for job resources that they gained in the music projects. Later, in section 6.1.2.1 on *Conclusions and discussion*, these identified aspects will be placed into the framework of the Job Demands and Resources (JD-R) model of Bakker & Demerouti (2014).

5.3.4.1. Gaining new contact with, and insights into patient(s) and resident(s)

A central learning benefit for the healthcare professionals in both care contexts appeared to be the new awareness of the possibilities to improve care delivery through the emerging insights into participatory music-making (see section 5.2.4.2). This view was corroborated by interviewees in both care contexts. For example, caregiver Theresa explained:

> *Music can substitute for verbal language. Music can express anything; express emotions. Especially with these people [with dementia], they can show how they feel through the music. Then, you can better take action [as a caregiver], I think.*

Likewise, coordinating nurse Werner reflected:

> *Yes, exactly, because the patients become more accessible to us. So, you are able to help them better. That is very important. And you learn more about their background. You can help them better knowing what you know then. Or try to help them. You cannot help all of them, but you still can try.*

The benefits of the new contact or insights often led to an increase or deepening of the communication and interaction between the healthcare professionals and the patients or residents. Eventually, the increase of communication had a direct benefit for the care delivery. Nurse Alexandra explained in an interview (from Smilde et al., 2019, p. 103)[135]:

> *So, if [the patients] show their emotions, it is easier for us to respond to them. Sometimes it can be quite difficult to talk about emotions, to start talking about it, but if someone gets, well a piece of music, then you can ask: 'How did you feel about that?' 'I saw you were quite moved, why was that?' So, you have an opening to talk with your patient a little more communicatively.*

The experienced new contact appears instrumentally beneficial for providing person-centred presence care (see also Kitwood, 1997; Youngson, 2012; Van Heijst, 2005).

5.3.4.2. The increase of the patients' acceptance of the care

Healthcare professionals in both researched contexts stated that the music sessions facilitated later care procedures, as the patients and residents' willingness to accept care seemed to increase during (e.g. wound care) and after the music-making. Coordinating nurse Jessica explained:

> *Yes, it really opens quite a lot of doors. The patients are relaxed; more relaxed in their beds, which makes it easier to start a conversation with them. And it breaks the day, also for the staff. Yes, of course, it takes time. Healthcare professionals are always talking about time. We are busy, we have to do this, that and the other. It takes time, but you also get something in return, because the patients are more relaxed, happier. Sometimes, you have to make a great*

135 I have used this data in the previous research on the MiMiC practice, in which I took part (Smilde et al., 2019, p. 103).

effort to get something done. Like, 'You have to get out of bed, that's good for you; for your lungs and your arteries.' And now it is like: 'The patients are more cheerful and happier.' And then they are like: 'Yes, I would like to get out of bed. That's okay.' So, the process continues like that, as well. Yes, I do notice a great difference.

Similarly, in the nursing home care context, caregiver Anna reflected in an interview:

Well, actually during [the project], I thought: 'Yes, it is a good idea to start singing.' Especially if [the residents] indicate that they want it themselves, like a song from their youth. Often, I know the songs, as well, because I am closer to their age than someone who is 25 years old. So, I am able to sing these songs with the residents. And, well, I think that… people are really flourishing when we do this, and then, you do have a connection with them again. […] Then it is easier to get something done. For example, washing and getting dressed.

These described benefits for the care delivery show direct instrumental support for the healthcare professionals' job resources. Similar notions have previously been made in the Musique et Santé forestudy (see section 2.1.2).

5.3.4.3. Experienced increase of job satisfaction

Through the experienced atmospheric changes in the workplace (see sections 5.2.3) that the music sessions appeared to create, the healthcare professionals reflected upon a perceived increase of job satisfaction. Coordinating nurse Gina stated:

I think it is wonderful when there is music [at work]. I think the music that [the musicians] make is really beautiful, generally. It is not always my taste of music, but generally, I find that the way [the musicians] perform it, it provides me a lot more job satisfaction.

Similarly, coordinating nurse Jessica called it 'breaking the day' in an interview:

For myself, a few times I was behind the desk working, while the music was sounding. And then, I heard it through the corridors. They are all U-bends, so the sound always came back to me. I think that it really breaks the day in a positive sense. You hear a good kind of noise in the ward. Usually when there is something going on, it is not good.

It was, however, not only the perceived atmospheric changes in the working environment or the enjoyment of the music-making that seemed beneficial for increasing the healthcare professionals' feelings of job satisfaction. It was also the perceived positive social changes that were brought on by the music sessions. Activity leader Jane and caregiver Mathilde reflected in a group discussion upon a question about the significance of gaining a closer bond with the residents:

Mathilde: *To be able to respond better to the needs of the resident.*

Jane: *You also have a better working day for yourself. If someone is grumpy, it is not fun for yourself. And if you are tuned into each other, it is a lot less stressful for the resident and therefore, also for us. And consequently, the resident feels that, too.*

Furthermore, job satisfaction could be supported by stimulating moments of creativity and imagination (as suggested in section 5.2.3.2). Reconstructed from the fieldnotes:

> The musicians start the session in the nurses' breakroom. The room is full of people to the point where the musicians discreetly search for a small place between the nurses in which to position themselves. Cellist Roy introduces the trio once more and tells that the musicians would be there at the ward until the end of the week. Roy tells the nurses that the musicians would like to improvise for them today to give a moment of relaxation. The nurses burst into a friendly laughter. Roy repeats the idea: '*To [help you] relax for a bit.*' He explains that the musicians use improvisations in the patients' rooms; the patients can decide on a landscape or another kind of an idea for a piece. Roy explains that today, the musicians would like to make a piece of relaxation especially for the nurses.
>
> The piece sounds atmospheric and calming. When it comes to an end, one of the nurses makes a comment: '*I have never been to Scotland, but this sounded like the Scottish landscapes to me.*' Another nurse replies: '*It was like Scandinavia to me.*' A third nurse joins the commentary: '*For me it sounded a bit like Arvo Pärt's Spiegel im Spiegel.*'
>
> When it is time for the musicians to leave the room, Roy invites the nurses to the patients' rooms to make music together or just to listen. Then, he wishes them a good workday.

Here, again, the concept of imagining through music (see Turino, 2008) as a resource for subjectivity (see DeNora, 2000) seems plausible. As previously explained in section 3.3.3, an increase of job satisfaction can positively influence work engagement leading to a higher job performance (Youngson, 2012; Bakker & Demerouti, 2014; Lases, 2017). Thus, these accounts, which address the perceived benefits of participatory music sessions, may offer a relevant contribution to the discourse on healthcare professionals' occupational well-being.

5.3.4.4. Gained confidence, tools and strategies for using music at work

In the Music and Dementia practice, the caregivers joined the music sessions as co-participants with the musicians and the residents (see section 2.3.2). Afterwards, the caregivers described having learned new strategies for using music at work. These 'tools', as they called them, seemed to increase their sense of confidence to employ music in the care. Caregiver Theresa stated in an interview:

> *Yes, it gives more confidence. […] If [the musicians] can achieve it here, where everyone is so calm and everything is very tranquil, then I must also be able to recreate it on the ward. That may not be today or tomorrow, but I can take [the new ideas] along.*

In another interview, activity leader Jane described the new ideas for carrying out musical activities with the residents:

> *For me, it is [all about] the intimacy [of the circle]. It is precisely those small groups that we really have to start looking at.*

Later in section 5.3.5, the caregivers' motivations for sustaining the legacy of the music projects with the new tools and strategies that they gained from the music sessions are examined in closer detail.

5.3.4.5. Gained concentration and mindfulness

In section 5.2.3.1, it was proposed that the live music practices could catalyse moments of mindful concentration for the healthcare professionals in both care contexts. The benefits of the described changes in the interviewees' mood and focus seemed to increase their *personal resources* at work (see also Bakker & Demerouti, 2014). Social worker Doris explained:

> *I go there as a social worker, and the music [suddenly] focuses me, so I stand still. If you look at what the music does for me, I think I am in the present moment through the music. So, I am open and can enjoy what is there; the sound of music.*

Similarly, in a group discussion, nutrition assistant Ava added:

> *Yes, just getting away from the hectic day; just being in the moment.*

These described moments of concentration and mindfulness (see Langer, 1989 in section 3.3.3.3) seem important for increasing the personal resources to carry on working during hectic workdays. In line with the concept of flourishing, engagement with one's environment through an enhanced focus on and attention to the present moment can contribute to occupational well-being (see Seligman, 2011 in section 3.3.3).

5.3.4.6. Gained feelings of energy and excitement

Connected to the experienced increase of job satisfaction above (see previously in 5.3.4.5) and the experienced environmental and emotional changes in the music sessions (see sections 5.2.2 and 5.2.3), the healthcare professionals described music-making as a resource for energy and excitement. In the MiMiC practice, physiotherapist Reinder summed:

> *Yes, it gives a new impulse. You get a kind of a 'booster'; you can get new energy from it. And also, some, yes, joy, some 'zest' for life.*

Likewise, in the Music and Dementia practice, caregiver Mathilde and activity leader Jane explained in a group discussion:

Mathilde: *Yes, it also gives you energy, just by being there.*

Jane: *Because you do become enthusiastic just by sitting with [the residents].*

Jane continued to explain that the positive new energy and excitement could last past her work shift:

> *When I get home later today, I will go and tell [my family] that we have done 'Music and Dementia' again. And then, I will say: 'It was so much fun and someone did this and someone else did that.' So, I can re-enjoy [the session], you know. That, also, gives energy.*

In line with the acknowledgement of job and personal resources by Xanthopoulou et al. (2007), it can be suggested that the energy and excitement from the music sessions may benefit the immediate care delivery, but also, more holistically, support the healthcare professionals' feelings of well-being beyond the situations in the workplace.

5.3.4.7. Relaxation and calmness through music

Given the ever-growing job demands of healthcare professionals (see Lases, 2017 in sections 1.1 and 3.3.3.4) and due to the strained time resources and unbalanced staffing levels (see section 5.1.1), it is understandable that the healthcare professionals in this research considered the feelings of relaxation and calmness of the music sessions as beneficial for their occupational well-being. Physiotherapist Reinder reflected in an interview:

> *Of course, it is true that we live in a time where [everything goes according to the clock]: 'tick-tick-tick.' Everything has to happen [instantly], so there is of course an enormous workload. And the question is whether you can afford to add such moments [of music-making] on one hand, and on the other hand, it can only be good in terms of health if you have a moment of calmness, right? Just a moment to get back to the important things in life.*

Similarly, nurse Frederik recalled his experience of the relaxation that the MiMiC practice created on his ward as an "*oasis of tranquility*" that enhanced his well-being at work and supported his contact with his patients. Frederik described in an interview:

> *It is really just an 'oasis of tranquility' that is all around you. You notice it throughout the day. I think it is very important. You just really tune into the person and just receive this sense of calm on the ward, no matter how the day is going.*

5.3.4.8. Positive emotionality at work

The analysis suggested that there is a clear connection between sympathetic joy (see also Ricard, 2013 in section 3.3.3.2) for the vulnerable people to whom one gives care and the experienced support for one's personal resources at work. Caregiver Eleanor reflected in a group discussion:

So, it is very nice to see that [the residents] calm down with a big smile; that they really enjoy themselves. Even though they cannot always say it, you can clearly see it. That works very well and that is what you do [your work] for. That is why I started working in healthcare; to make it a good day for the people.

Sympathetic joy as a resource for care was once again emphasised in a group discussion following a MiMiC project:

Q: *And for your work, what can the music mean? What is important for your work?*

Hannah: *You are with your patient. You can observe what [the music] evokes in your patient, but it is also for yourself; you listen, and you can act upon it. If someone gets emotional, then you can do something about it, you can respond to it. I find it wonderful.*

Merel: *It gives me joy.*

In the reflections above, it can be seen that the articulated experiences of sympathetic joy appeared to resonate with the caregivers and nurses' professional identities (see also Ten Hoeve, 2018 in section 3.2.3), as well as reinforce the purpose and meaning of their work for themselves (see also Jormsri et al., 2005). Furthermore, it has been proposed that the music sessions may have evoked feelings of personal recognition, inclusion, respect and received kindness among the healthcare professionals (see sections 5.2.4.4; 5.2.5.6). It can be interpreted that, in line with the PERMA model of well-being (see Seligman, 2011 in section 3.3.2), these positive emotions might feed into the healthcare professionals' job resources and satisfaction. The aspect of recognition as a resource for positive emotionality was, once more, brought up in a group discussion by nurse Erica:

I just love it. I thought it was a very luxurious thing to have on the ward. I thought: 'These [musicians] are coming here just to play a song for us.' So, I thought it was an indulgence, really. I really enjoyed it.

5.3.5. The legacy of the music practices: motivation for sustainable change

It seems clear that there were contextual differences between the two participatory music practices, MiMiC and Music and Dementia, which impacted the healthcare professionals' participation in the music sessions (see section 5.1.4). These contextual differences also appeared to impact the healthcare professionals' motivations for the continuation of the music practices. It can be argued that in time, in both care contexts, the healthcare professionals may have become increasingly supportive of the music practices taking place on their workplace and subsequently, they expressed strong willingness for the practices to continue.

Yet, it seemed clear that only in the long-term care context of Music and Dementia practice, the caregivers displayed an especially strong motivation to carry on the legacy of the practice by themselves. They expressed a motivation to apply the music in their care work and most importantly, sustain the cultural changes that the music project had created.

Caregiver Theresa stated in an interview:

> *I think it's important that we implement this [into the care]. I do not play any instrument; however, the goal is that it is about giving space and respect [to the residents] and letting them be who they are. […]. I sense it in these sessions especially. The music is not that important to me anymore. It was at first. What is important is that now you really see the true self of the resident and what kind of an impact the music can have. We need to make time for this, and we want to. I hope to take this [insight] further in my work and also, to introduce this concept to my colleagues slowly, and to be an example: 'You can create [the calmness] by yourself in the living room [of the ward], instead of being restless and busy all the time.' Maybe just during those moments when people feel a lot of unrest. […] Perhaps it is important at exactly those times that you take the time to listen to them.*

Theresa's reflection upon the message of the Music and Dementia practice echoed the end goals of the staff training and development programme of Music for Life (see Smilde et al., 2014 in section 2.1.1), which showed that Theresa seemed to have moved far towards *relationship-centred care* (Garrett, 2009) on the spectrum of care cultures (ibid.). Theresa continued to emphasise the need to find ways to sustain the legacy of the music practice collectively within the community of practice. She stated:

> *Luckily, I have now two colleagues [at my ward], who know what I mean, and who also say: 'It was so special, I got goose bumps!' Then, we can support each other, and [the continuation of the practice] does not only depend on me. If you would have to do it alone, it would be difficult.*

The main challenge for rooting the learning benefits as a legacy of the music practice into the care unit seemed to be that only a small number of caregivers have gained first-hand experience of the music sessions. Theresa continued:

> *It remains difficult for [the colleagues] to understand what you mean without having the experience. Actually, everyone should experience it once. As they sit back and relax, they can really feel it.*

In terms of the practical implementations of music-making in the nursing home care, the utilisation of one's voice and simple music instruments seemed to be considered as possible for the caregivers. Theresa explained:

> *And yes, because some people cannot express themselves well in words anymore, you can actually use a music instrument or sing, so they can join in […] And then, there is also the welcome song. [The residents] can be part of it, too.*

However, without the experience of the music sessions, it could be difficult for the caregivers to feel comfortable using music at work. Mathilde speculated:

> *I don't think that a lot of colleagues feel free to do it.*

Caregiver Eleanor believed, on the other hand, that sustaining the legacy of the music practice could happen through gradual implementations of person-centred musical moments in the care: "*Yes, step by step.*" Eleanor continued to envision how healthcare professionals could begin to use music in the care:

> *When there would be more [colleagues] who have [participated in the music project], then they could simply take some instruments and start. It does not have to sound like in the [Music and Dementia] sessions; they are with professional musicians. But you can also do [something] very simply.*

The sustainability of the learning benefits of the music sessions seemed to require willingness to step out of one's professional 'comfort zone', as proposed previously on the challenges of allowing oneself to participate in the sessions (see section 5.1.3.1). Eleanor concluded:

> *Maybe it is a utopian thought, as now the music is still very new. [The caregivers] are busy with their work and do not yet understand it, or do not dare. But if it would become a regular part of the day, just like [the residents'] hairdresser's appointments, it would be wonderful for the people who would benefit from it; those who would like to have it.*

In line with the perspective of philosophical pragmatism, it seems that the value of the music projects is connected to the developmental possibilities that they offer for the caregivers. Here, finding means to apply the musical approaches into care and finding ways to maintain the evoked cultural changes of person-centredness seem paramount for the caregivers (see also Westerlund, 2008; Väkevä & Westerlund, 2009 in section 3.1.7). It appears that the accumulated first-hand experiences of the musical processes and reflection thereon may empower caregivers to reinforce the perceived positive impacts of the music-making in the workplace through one's own actions. Such aims can be interpreted as a pursuit of reconstructing the culture of the care community, thus demonstrating the core pragmatic notions of learning (see also Dewey, 1938/2015).

6. CONCLUSIONS AND DISCUSSION

6.1. Main findings

The title of this dissertation, "Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals", accentuates the all-encompassing objective of the research to map out the ways the two observed music practices, MiMiC and Music and Dementia, benefit the nurses and caregivers' professional development and well-being. To revisit the two research questions of the study (see section 1.5), this research aimed to find out, first, what kind of knowing is transferred from the participatory music sessions into these above mentioned healthcare settings, and second, what resources and social changes can they generate for the nurses and caregivers' daily care routines, and what kind of impact can they have on their working culture. The conclusions of the findings address these research questions, respectively.

6.1.1. New knowing and awareness

1) *What kind of knowing is transferred from interactive music sessions into daily healthcare practices in elderly care and hospital settings?*

The processual nature of the healthcare professionals' experiential learning within the music practices manifests in the narrative accounts as a cumulative development of new awareness and knowing. This accumulation of knowing aligns with Dewey's (1938/2015) principle of continuity (see section 3.1.2). In particular, the development of new knowing from the very first moments of familiarisation with the music practices to a growing awareness is narrated in the interview and group discussion data.

As described in the previous section 5.3, 'Learning benefits', the data of this research suggests that the healthcare professionals who participated in the MiMiC and Music and Dementia practices gained new value-based awareness of their contact with their patients and residents. The reinforced understanding of person-centred contact, stemming from the participatory musical processes, can be transferred from the music sessions into the daily care practice. This is because the healthcare professionals' articulated meaning-making suggests that they perceive person-centredness as a core value of the music practices; the concept of person-centredness resonates closely with the fundamental values of person-centred care (see Kitwood, 1997; Bunkers, 2010; Youngson, 2012 in section 1.2). Thus, the two music practices, MiMiC and Music and Dementia, which employ different approaches to person-centred music-making (see Smilde et al., 2014, 2019 in sections 2.3.1, 2.3.2) seem to communicate the principles of person-centredness in a way that can be accepted as a shared value by the healthcare professionals.

Most importantly, the musical processes that aim to support patients or residents' agency (e.g., expression of musical needs and taking creative ownership of the music-making) are recognised as a counterpart to person-centred care by the healthcare professionals. Person-centred care is, above all, concerned with respecting the patients' opinions, preferences and personhood in the planning and delivery of the care (see also

Kitwood, 1997). As the healthcare professionals' resources for person-centred care can be limited in practice due to time pressure (see also Lases, 2017), the value of the person-centred music-making as a cultural complement for care delivery can be deemed significant (see also coordinating nurse Jessica's account in section 5.3.2.2) [136].

The findings of this research suggest that through the musical interactions, the person-centred values of the care can be reinforced in action, as in the case of nurse Amanda and her patients Mr. Smit and Mr. Kleine (see again section 5.2.3.2). In such kairotic moments of *enhanced intersubjectivity* (see also Cohen-Salmon, n.d., p. 3, in section 2.1.2), person-centred music-making appears to create a platform for displaying compassionate care (see also Youngson, 2012). However, achieving it requires healthcare professionals' openness to collaborate with the musicians. Also, healthcare professionals need to feel included in the music-making. When these needs are met, the healthcare professionals' agency and co-participation (see Billett, 2007) in the music sessions, as well as their acceptance and appreciation of the musicians, can grow. Receiving collegial support from those nurses and caregivers who seem to take the role of 'old-timers' (see Lave & Wenger, 1991) in the music practices, as well as the musicians' perceived friendliness, kindness and hospitality (see Higgins, 2008, 2012; Lines, 2018 in section 3.2.5), facilitate this process of growth.

The healthcare professionals' personal musical taste, relationship with music and understanding of own musicality, which functioned as facilitating or limiting factors of participation at the beginning of the music projects (see section 5.1.2), became gradually less significant for their experiential learning processes. It can be concluded that through observing and experiencing the changes that are catalysed by the music-making in the two care contexts (see section 5.2) – in particular the healthcare professionals' perceived positive impact of the music-making on the patients and residents' well-being – it becomes less relevant whether or not the music is to the healthcare professionals' own taste. What can be achieved with the music-making for the benefit of the patients and residents is what nurses and caregivers seem to value the most.

These findings align with Dewey's (1938/2015) pragmatic notions of meaning-making and learning (see also Elkjaer, 2009; Väkevä & Westerlund, 2009; Caldwell, 2012), as well as with Mead's (1934/2015) concept of the 'social self' that is constructed through interactions with others by looking through the eyes of 'the other'. In this research, Mead's (ibid.) notions of the social self also provide a framework for explaining the difficulty some healthcare professionals experienced when reflecting on the music-making from their own perspective instead of the patients' or the residents' viewpoints.

It appears that the healthcare professionals' sense-making of their musical experiences is intertwined with the perspective of 'the other'. This is clear in caregiver Theresa's account where she described the experience of personal recognition and inclusion on behalf of the residents (see section 5.3.2.2), as well as in coordinating nurse Jessica's reflections on the impact of the music-making on the patients' acceptance of the care (see section 5.3.4.2). The healthcare professionals did not, however, appear to be aware of this interconnectedness in their narrative accounts, which may be related to their highly developed professional identities (see also Ten Hoeve, 2018 in section 3.2.3).

136 These findings align with the forestudy on Musique et Santé, where social care coordinator Mohamed Bouazouzi explained: "*All the patients are first social persons, so we try to create activities that involve their personhood. […] The meaning is to meet the people, to make the hospital not just a bed but a place of life*" (see section 2.1.2).

6.1.2. The generated resources, experienced changes and impact of music on working life

2) *What resources and social changes can music sessions generate for nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?*

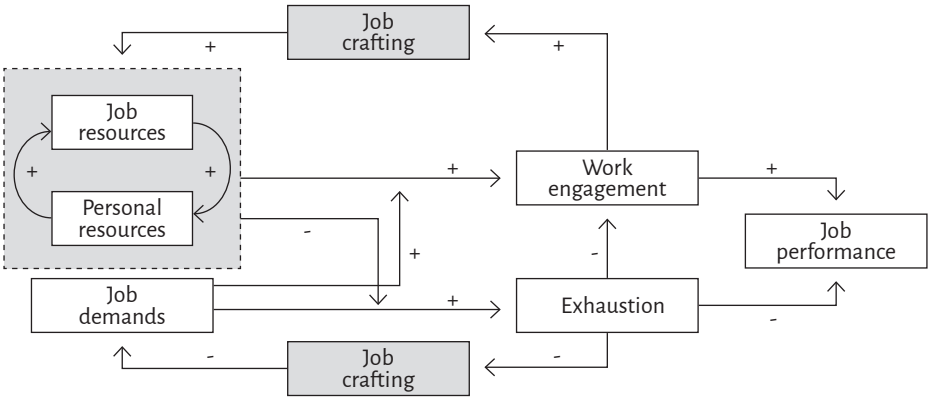
6.1.2.1. Generated resources for work

When focusing on the occupational well-being of healthcare professionals in this research, it is helpful to position the findings into Bakker & Demerouti's (2014) occupational Job Demands and Resources model (JD-R) of well-being (see section 3.3.3.5). The JD-R model, which theorises facilitating and limiting factors related to work engagement and job performance, can contextualise findings from this study, and help explain how nurses and caregivers experience their job- and personal resources. The JD-R model, as well as the previous theorising of Xanthopoulou et al. (2007), distinguishes between a person's *job resources* and *personal resources* within her/his occupational context, which helps to categorise the emergent resources from the music practices.

Although participatory music projects seem to be helpful for increasing healthcare professionals' job resources and personal resources at work, they should not be viewed as a proposed solution for all job demands. However, Xanthopoulou et al. (2007) argue that resources can generate new resources or 'resource caravans', which can have significance for occupational well-being (p. 123). For example, as explained previously, live music can evoke positive emotionality at work, which can support the healthcare professionals' job satisfaction (see section 5.3.4.8), which in turn is significant for balancing out some job demands.

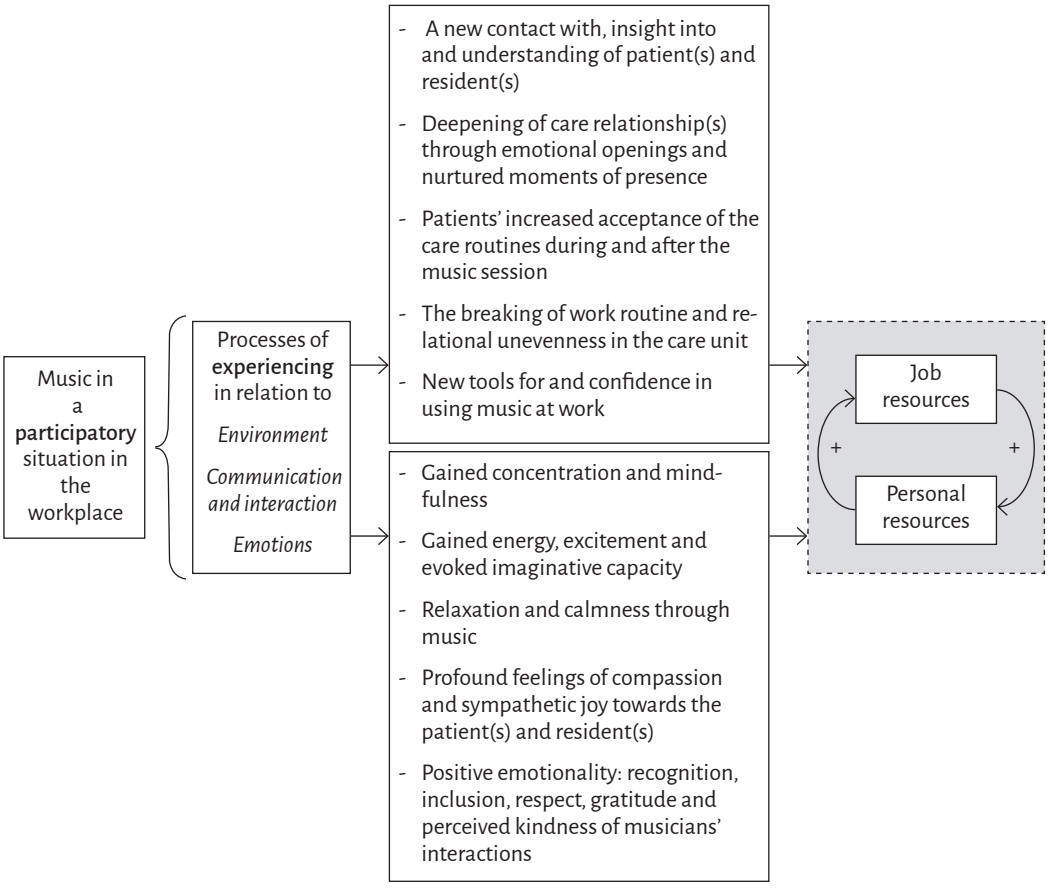
When examining the JD-R model (see below), live music practices should be considered as an external, complementary cultural service that is introduced to the care context. Thus, as the music practices are not part of the dynamic occupational processes of the JD-R model, a newly added visualisation is needed for proposing how the musical experiences may contribute to the healthcare professionals' resources, and subsequently their work engagement, job performance and even job crafting (as defined in section 3.3.3.5).

Revisiting the Job Demands and Resource model after Bakker & Demerouti (2014, p. 10).



As an addition to the JD-R model, the learning benefits of the music practices can be categorised as support for job resources for personal resources. See Figure 5 below for the suggested visualisation of the musical processes feeding into the healthcare professionals' occupational[137] resources.

Figure 5. Identified learning benefits of participatory music practices feeding into the occupational resources of healthcare professionals (after Bakker & Demerouti, 2014).



137 Although the analytical lens of this research focuses on the identified learning benefits for healthcare professionals' occupational well-being in the situated context of music-making in their workplace, the theoretical positioning in philosophical pragmatism considers learning as a holistic process (see Yorks & Kasl, 2006 in section 3.1.1). Thus, the interviewees' professional and private meaning-making of the musical experiences cannot be separated by drawing a hard line. Instead, in some of the interview accounts of this study, the healthcare professionals' reflections upon their musical experiences and learning at work seemed to blend clearly with their meaning-making of music in their private lives, e.g. musical habits and past musical experiences (see section 5.1.2.2).

6.1.2.2. Experienced changes and impact of the music practices

Many of the identified experiential learning benefits that can be seen as contributing to the healthcare professionals' job and personal resources are linked to (a) the components of well-being as presented in the PERMA model (Seligman, 2011, see section 3.3.2), (b) the concepts of positive emotionality and compassion at work (see Ricard, 2013; Compton & Hoffman, 2013 in section 3.3.3) and (c) mindfulness in work engagement (Langer, 1989; Lases, 2017 in section 3.3.3.3) – all of which are core theoretical notions of this research.

Regarding experienced changes in the atmosphere of the clinical environment and one's mood, the findings of this research suggest that live music is a powerful resource for subjectivity and self-production (after DeNora, 2000), as well as imagination and emotionality (Turino, 2008). This means that the music-making may transform the healthcare professionals' experience of their surroundings by evoking musical imagining, which might create a sense of 'transportation'. In the MiMiC practice, the nurses' experiencing of such changes did not depend on 'full participation' (see Lave & Wenger, 1991), as suggested, for example, by the interview account of nurse Alexandra (see section 5.2.3.1).

In addition, live music might work as a change agent for the healthcare professionals to become mindful of the present moment (see Langer, 1989 in section 5.2.3.1). Many of the interviewees called this experience 'Zen' which appeared to foster flourishing (see Seligman, 2011) in kairotic moments of music-making (see also Sipiora, 2002; Loney, 2018; Rusi-Pyykönen, 2020 in section 3.3.3.3). The gained mindfulness could, subsequently, help nurses and caregivers to become more present and organised during the care delivery[138]. Presence is a central value of person-centred care (see Benner, 1984/2001; Van Heijst, 2005), which resonated with the interview accounts and group discussion data of this research.

Furthermore, participatory music-making could lead to experienced social changes in the communication and interaction among colleagues and with patients or residents. The shared musical moments helped to temporarily balance the hierarchy of the social structures among the hospital work community and allow colleagues to see new, often emotional sides of each other. In Goffman's (1959/1990) terms, this change can be seen connected to the relaxing of the 'front' of the professional performance (see sections 5.1.4.3, 5.2.4.1 and 5.2.4.2). When it comes to communication with the patients and residents, participatory music-making could catalyse openness for contact, which enabled the healthcare professionals to gain new insights into them (as previously discovered by Smilde et al., 2014, 2019). Such social change may be crucial for the development of care relationships, as the healthcare professionals might, then, be able to respond better to the patients or residents' needs (see section 5.3.4.1). Hence, participatory music can be argued to have potential for fostering compassionate care and presence (see also Van Heijst, 2005; Youngson, 2012), also among patients or residents.

The social changes of increased openness and connectivity are nurtured by the experienced intimacy of the musical situation, where the musicians' 'hospitable' interactions (see Higgins, 2008, 2012; Lines, 2018) are perceived as kind, friendly and

138 These findings align with the forestudy on Musique et Santé, where social care coordinator Mohamed Bouazouzi stated: "*You can become more 'zen', calmer and de-stressed. […] And we try to move the nurses to this way of working; to have more patience with the patients, to engage in the relationship*" (see section 2.1.2).

respectful. Gradually, the healthcare professionals develop feelings of appreciation, respect and gratitude towards the musicians' professional values. This development also appears to add to the healthcare professionals' positive emotionality and satisfaction at work, which aligns with Compton & Hoffman's (2013) notions of the components of occupational well-being (see section 3.3.3).

The new knowing and awareness that healthcare professionals gain from participating in the music sessions can help them to reconsider their own ways of working and even critically examine some of the aspects of their working culture. Especially when it comes to the musicians' ways of working as a team and with the patients, residents and healthcare professionals, the nurses and caregivers alike imply that the musicians' humanistic values, collaborative skills and communicative qualities are particularly beneficial for supporting care (see also section 3.2.5). Another key learning benefit seems to be recognising the interconnectedness of one's own mood and emotions, and those of the patient(s) or resident(s) (see, e.g. caregiver Wilma's reflection in section 5.3.3.1). This kind of development, again, suggests that Mead's (1934/2015) notion of the 'social self', looking through the eyes of 'the other', is relevant for conceptualising the findings of this research (see section 3.2.3).

Becoming aware of the two catalysed processes of opening up emotionally and getting closer to one another seems important for the development of compassionate care relationships. Through shared musical moments, the healthcare professionals can be brought to a level of *emotional resonance* (see Ricard, 2013 in section 3.3.3.1) with the people to whom they give care. Emotional resonance is based on empathy towards the patients and residents' vulnerability (ibid.). Sometimes, allowing oneself to become emotionally moved by the music was restricted by the need to keep the front of the professional performance intact (see Goffman, 1959/1990 in section 3.2.4). Yet, the healthcare professionals' underlying feelings of empathy for the patients and residents could be cultivated into an active display of compassion through the music-making (see section 5.2.5.4). Hence, it can be argued that participatory music-making might support compassionate care.

Lastly, as suggested by caregiver Eleanor (see section 5.2.5.4), it appears that participatory music practices have the potential to support compassionate person-centred care delivery beyond the music project. Such an interpreted legacy is in line with the forestudy on Music for Life (see section 2.1.1), where the change from a task-centred work culture towards a person-centred work culture was considered as possible through facilitated reflection upon the shared musical experiences.

6.1.2.3. Sympathetic joy through musical experiencing: resources for flourishing at work

Reflecting on the findings of this research on healthcare professionals' experiences of emotionality, it seems clear that sympathetic joy; the rejoicing for the well-being of the other (see Jomrsri et al., 2005; Ricard, 2013 in section 3.3.3.2), is a fundamental change agent in healthcare professionals' experiential learning processes, which eventually lead to the legacy of the music practices. Sympathetic joy has a role in both core categories, *Participation* and *Experience*, that lead to the *Learning benefits* of the music practices.

First, sympathetic joy is significant for changing the initially sceptical attitudes of

some nurses towards the MiMiC practice, because rejoicing for the patients' positive musical experiences seemed to increase the nurses' positive emotionality and stance towards the music sessions. The change of an attitude could, then, help most nurses to move closer towards full participation (see Wenger, 1998) in the music practice. Second, as indicated above, the healthcare professionals' validation and meaning-making of the music practices for themselves were fundamentally interconnected with the perceived benefits and values of the music-making for the patients and residents (see section 5.3.2). When the shared musical experience was perceived as positive for the patient or resident, healthcare professionals seemed to experience it positively for themselves, as well. This interconnected rejoicing for the musical flourishing (see DeNora & Ansdell, 2014) of 'the other' could help to create moments of flourishing at work for the healthcare professionals (see section 5.3.4.8). Subsequently, sympathetic joy might be considered to contribute positively to healthcare professionals' job satisfaction and occupational resources.

Although the healthcare professionals did not seem to be explicitly aware of their experiences of sympathetic joy, their narrations of positive emotions during the music sessions were profoundly connected to seeing the patients and residents supposedly flourishing through the musical interactions (see again section 5.2.5.5). Thus, it can be concluded that the healthcare professionals appear to attach significant and profound value to the music-making, as well as personal feelings of fulfilment to the rejoicing for the well-being of the patients and residents in the musical situation.

6.2. Participatory processes underlying experiential learning

It has been argued that the healthcare professionals' participation in the music practices typically followed a process of moving from legitimate peripheral participation towards full participation (see also Wenger, 1998 in section 3.2.2). In the MiMiC practice, the movement happened flexibly back and forth between the two, depending on the situation at work. In the Music and Dementia practice, the co-participants' engagement in the circle was also multi-layered and dynamically moving within a spectrum of legitimate peripheral participation (see also Smilde et al., 2014). However, it was clear in the analysis of this PhD research that the interviewed caregivers felt they had a different kind of *agency* while participating as an observer outside the circle and while co-participating in the circle. Being in the circle was often described as more rewarding than observing due to having more agency in the collective processes of music-making. On the other hand, observing seemed to feel safer for some caregivers.

Moving into the circle of the music sessions could be a daunting challenge for some caregivers, as it required stepping into an unfamiliar role of a music-maker (see sections 5.1.3.1, 5.1.4.3). Some caregivers moved quicker towards the focused action of music-making than others. There were many reasons for that, e.g. personal motivation or a close relationship with music (see section 5.1.2). Those caregivers who moved quickly towards full participation could take the role of *old-timers* (see Lave & Wenger, 1991) and encourage those colleagues who were hesitant or daunted to take part in the music-making. Furthermore, first-hand observation of the residents' responses to the music-making served as a significant facilitating factor for helping caregivers to move from the periphery

of the practice closer towards full co-participation.

Contextual factors (e.g., the situation at work) and personal factors (e.g., musical preferences) created conditions for the healthcare professionals' participation in the music session (see sections 5.1.1 and 5.1.2). Openness and curiosity, as well as a strong personal relationship with music, were significant facilitating factors in the individual healthcare professionals' preliminary attitudes towards taking part in the music sessions. Dewey's (1938/2015) principle of continuity (see section 3.1.2) was central for explaining the gradually evoked curiosity and changing of attitudes towards the music practices among some healthcare professionals.

Self-allowance to participate can be viewed as a key milestone for moving from legitimate peripheral participation towards full participation in the music sessions. Especially in the hospital, the self-allowed participation could diminish the nurses' professional distance by increasing their presence and agency (see also Benner, 1984/2001) in the musical interactions.

Goffman's (1959) notions of the *professional front*, *impression management* and *backstage region* can be considered as fundamental for explaining the limitations and possibilities of the healthcare professionals' participation in the music sessions. When applied to the musical situations, nurses in particular seemed to have a need to keep their professional fronts intact in the presence of their patients through impression management (see section 5.1.4.3) Yet, in the privacy of the patients' absence in the backstage region, 'dropping the front' (ibid.) allowed new dialogical processes to emerge between the healthcare professionals and the musicians.

Dialogue is necessary for the emergence of a community of practice (Lave & Wenger, 1991). The development of communities of practice in this research was characterised by a mutual recognition of and respect for professional knowhow, and an openness to learn from each other. At its most integrated form, the interprofessional collaboration could evolve into a synchronised way of working, such as in the episode of the wound care (see section 5.1.4.1). In this example, two nurses tended to the wounds of Mr. Smit while the musicians were allowed in the room to play for him and his fellow patient, Mr. Kleine. As an outcome, the nurses learned that live music during wound care distracted the patient from the pain but also relaxed the nurses themselves, which could be seen as beneficial for both the nurses and the patient.

6.3. The perspective of philosophical pragmatism

In line with the pragmatic philosophical perspective of this research, it seems that the value of the music practices for the healthcare professionals is connected to the developmental possibilities that the practices bring about in their work (see also Dewey 1938/2015; Westerlund, 2008; Väkevä & Westerlund, 2009 in sections 3.1.7, 5.3.2, 5.3.4). The value of the created social change goes beyond the perceived aesthetic qualities of the music. The findings of this research suggest that, at the beginning of the healthcare professionals' experiential learning process, the qualities of the music (e.g. genre, style, instrumentation, improvised or repertoire) were important for creating engagement, but as the healthcare professionals' experiences accumulated, the *social processes* that the music-making catalysed

became paramount for the perceived value of the music practices.

It appears that the contextual differences between long-term and short-term care supported different kinds of pragmatic considerations about the legacy of the music practices (see section 5.3.5). Unlike caregivers, nurses did not articulate a motivation to continue making music at work after a MiMiC project ended. Still, both groups of healthcare professionals recognised beneficial social changes and a new awareness of the communication that the music-making could bring into their care practice.

According to the pragmatic epistemology of this research, experiencing and experiential learning are closely intertwined (see Dewey, 1938/2015 in section 3.1.2). Dewey (ibid.) argues that experiences are usually evocative and therefore often spark reflection. In this research, the evocative potential of the music-making has been recognised as a central aspect of the healthcare professionals' meaning-making of their experiences in the music practices (see section 5.2.5.2).

Taking part in the music sessions first-hand was essential for emerging insights to accumulate (see section 5.2.1). In line with Dewey (1916/2009, see section 3.1.4), the experienced hesitation and doubt at the beginning of a music project that many healthcare professionals reflected upon, seemed significant for catalysing meaning-making of the music practices. Furthermore, it appears that the healthcare professionals' future-oriented *anticipation of consequences* (see Elkjaer, 2009; Caldwell, 2012) of musical participation had importance for their self-allowance to take part in the music sessions (see e.g. activity leader Jane's narrated process in section 5.1.3.1).

To create a change of a perspective, attitude or perception, the musical experience needed to be reflected upon, as learning from experience meant establishing a relationship between what was experienced and what followed afterwards (see Caldwell, 2012, p. 48 in section 3.1.3). For example, when looking back on coordinating nurse Werner's new understanding of his patient, Mr. Boekman (see again section 5.2.4.2.), it is clear that Werner's new perspective on Mr. Boekman's behaviour was a result of reflection on the musical interactions where Werner discovered new sides of him. As a result, Werner was able to adjust his attitude towards Mr. Boekman accordingly to the newly discovered needs of the situation.

6.4. Main differences and similarities between the two empirical studies

The research data suggests significant similarities and differences between the experiential learning of nurses and caregivers in the music practices within the two healthcare contexts.

The four key similarities between the studies are:

1) The shared musical experiences, which allowed healthcare professionals to see new sides of their patients or residents and other colleagues, served as a catalyst of compassionate contact between the healthcare professionals and the patients and residents. These findings are in line with Smilde et al. (2014, 2019).

2) The values of person-centred music-making echoed the values of person-centred care. When acknowledged by the healthcare professionals, this value-based awareness appeared to become an important justification of the music practices in care for them. The new value-based awareness seemed to facilitate small social changes, e.g. in the nurses and caregivers' contact with patients and residents. Similar processes were described in the forestudy of the Music for Life and Musique et Santé practices (see section 2.1).

3) The music practices created calmness and a sense of mindful concentration in the present moment amidst the hectic work environment, which healthcare professionals perceived to benefit the patients and residents' well-being, as well as their own occupational resources. Findings on the experienced moments of mindfulness through musical participation align with the concepts of work engagement and well-being (see Seligman, 2011; Compton & Hoffman, 2013; Lases, 2017 in section 3.3.3).

4) Emotional resonance through music-making, particularly healthcare professionals' interpreted feeling of sympathetic joy for the patients' or residents' positive musical experiences, was a core factor for supporting positive emotionality and satisfaction at work. These findings are in line with the concepts of workplace flourishing by Seligman (ibid.) and Compton & Hoffman (ibid.), as well as those of Ricard (2013) on the cultivation of positive emotions at work.

There are also three main differences in the findings between the two empirical studies:

1) The healthcare professionals' participation in the music sessions differed between the two music practices, which led to dissimilar participatory challenges and processes between the contexts of nurses and caregivers. In the MiMiC practice, the nurses could move flexibly between legitimate peripheral and full participation (see Lave & Wenger, 1991) and moderate the distance of their engagement at all times. It is important to note that the participation of some nurses did not evolve into full participation at all, sometimes due to the unpredictable circumstances. In the Music and Dementia practice, caregivers could also move within the spectrum of participation in the circle. Yet, their supported agency in the music-making nurtured a more proximal engagement in the circle than being an observer outside of it.

2) In the short-term care context of the hospital, the MiMiC practice appeared to have merit for helping to open up new points of contact between the nurses and the patients, which seemed to contribute to developing the short-term care relationship. In the long-term care context of the nursing homes, the Music and Dementia practice seemed to deepen the already existing care relationships between some caregivers and their residents. As the caregivers learned how their residents responded to the music-making during a project, many of them became curious to seek ways to employ music at work. They seemed to be motivated by wanting to support the residents in new ways and possibly enrich the communication in the everyday care with musical means.

3) The intention to apply music in one's work was emphasised in the long-term care context of Music and Dementia, where the caregivers displayed strong intrinsic motivation to employ their new knowhow of musical processes and music-making in their care work. The hospital nurses, on the other hand, expressed their wish to have the music practice to continue at their workplace without an intention to employ music in their work, which seemed contextually reasonable given the job demands of hospital work.

6.5. Discussion

6.5.1. Contributions of knowledge to literature and the field of practice

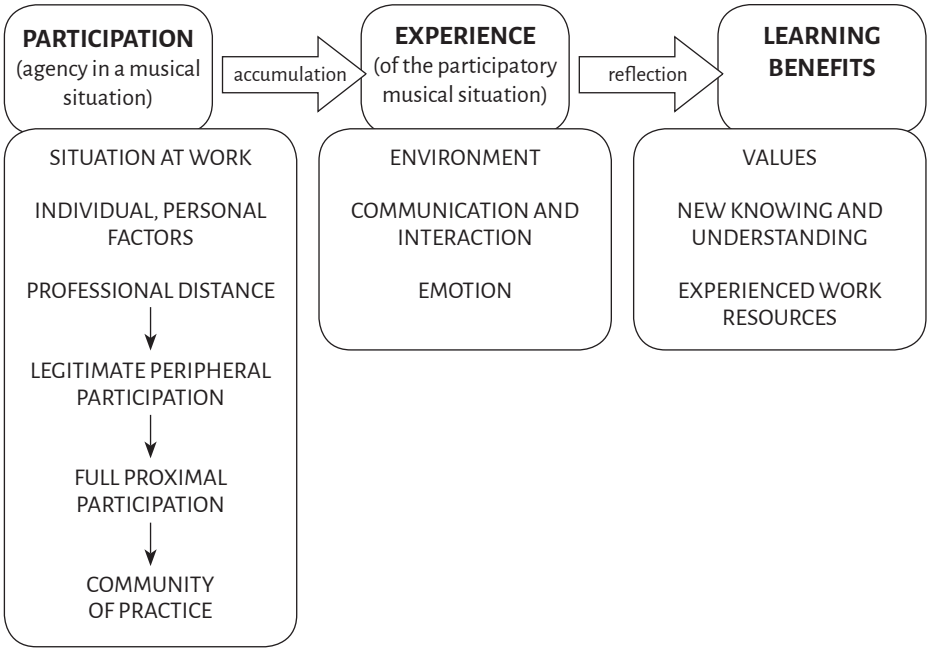
This research aims to contribute to the ever-growing body of knowledge of and development within the domain of music and healthcare. The largely overlooked perspective of this research, being that of healthcare professionals' experiential learning and occupational well-being, adds much-needed knowledge for filling the research gap among studies that primarily focus on music and its impact on the well-being of patients or residents.

Furthermore, this interdisciplinary research aims to contribute to a concept that has not yet been widely recognised in previous publications on music and healthcare. The concept is sympathetic joy or rejoicing (see Jormsri et al., 2005; Ricard, 2013; Gilbert & Choden, 2013), and it can add to the discourse of the cultivation of compassion in healthcare (see also Van Heijst, 2005; Youngson, 2012). This notion also presents a new perspective on how participatory music practices can support the healthcare professionals' positive emotionality, job satisfaction and hence, flourishing at work (see Seligman, 2011).

In addition, some of the findings of this research can contribute to the slowly developing research interest in music and mindfulness (see also Lecuona et al., 2014). Also, by positioning the healthcare professionals' experienced learning benefits in the framework of the JD-R model (see Bakker & Demerouti, 2014, p. 10), this research aims to add new knowledge of socially situated musical experiences and occupational well-being and learning. Such new knowledge may inform practitioners on both sides of the interprofessional collaboration: musicians and healthcare professionals.

Finally, the findings of this research can provide an additional perspective on the already published studies on Music and Dementia (see Smilde et al., 2014) and MiMiC (see Smilde et al., 2019), which may have further educational value for the professionalisation of music practitioners, as well as for institutes of higher music education in terms of curricular planning. The main contributions to this area would reflect the kinds of social, participatory and experiential processes that underlie healthcare professionals' learning in the music projects, and what kind of benefits the music practices can have for supporting their occupational resources and culture of work. See once more the visualisation of the new theoretical model of this research (figure 4 in section 4.5.5.3) in a simplified representation below:

Figure 6. (simplified based on Figure 4): Middle-range grounded theory model on the healthcare professionals' learning processes in participative music practices at work.



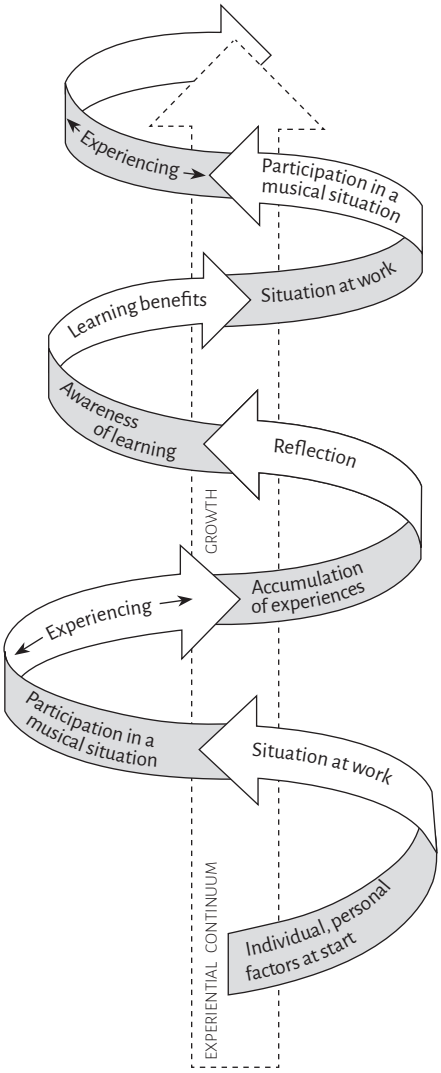
This model can be applied to the practice development of healthcare professionals and to increasing the contextual understanding of musicians working in healthcare. Concretely, this research aims to contribute to the knowledge base of a new international mixed-methods research project *Professional Excellence in Meaningful Music in Healthcare (ProMiMiC)*[139] that focuses on the interprofessional learning of nurses and musicians within the MiMiC practice, as well as the development of compassionate care through shared musical experiences between nurses and patients.

In addition, when viewing the processes of experiential learning within the framework of philosophical pragmatism, the model (Figure 6) can be translated into a visualisation of healthcare professionals' processual development of *growth* within the *experiential continuum* of learning in the music practices. As such, the new visualisation can

139 Professional Excellence in Meaningful Music in Healthcare, (ProMiMiC) (2019-2023) is a research project aiming to explore interprofessional learning processes and collaboration between musicians and nurses, between musicians and music therapists, and the increase of compassionate skills of nurses within the live music practice Meaningful Music in Healthcare (MiMiC). ProMiMiC is led by the Research group Lifelong Learning in Music of Hanze University Groningen. Partners in the project are University Medical Center Groningen, Research group Nursing Diagnostics of Hanze University, Royal Conservatoire in The Hague, Haaglanden Medical Centre The Hague, University of Music & performing Arts Vienna, Allgemeines Krankenhaus Vienna, Royal College of Music / Centre of Performance Science London, Chelsea and Westminster Hospital London, and Foundation Mimic Muziek. The project is co-financed through the RAAK-Pro programme of Regieorgaan SIA, part of the Dutch Research Council (NWO).

contribute to the discourse of experiential learning[140] in music by emphasising the forward- and backwards-looking connections of experiencing and agency, the relationality of the learner and the context of learning, as well as the accumulation of knowledge through the experiential and reflective processes underpinning healthcare professionals' meaning-making. See Figure 7 below:

Figure 7. Healthcare professionals' learning processes in participatory music practices within the experiential continuum of growth.



140 Similar to the additional visualisation of Figure 7, previous illustrations of experiential learning have been vastly presented in a spiral form. See, e.g. Knowles & Cole, 1996 in Compton & Davis, 2010, p.316.

6.5.2. Implications and recommendations for practice and policy

The findings of this research can add weight to the discourse on live music practices in healthcare as cultural initiatives responding to the ageing societies (see section 1.3). This research argues that the legacy of participatory music practices as a resource for healthcare professionals' well-being has significance for the quality of the care relationships (i.e., positive emotional resonance between the healthcare professionals and the patients or residents). Hence, person-centred music practices can be considered as a cultural counterpart for supporting person-centred care and practice development. Thus, this new perspective on live music practices as a complementary service for care delivery in hospitals and nursing homes can be introduced into the discourse of policymaking, towards supporting live music practices in healthcare.

6.5.2.1. Practical considerations and implications for healthcare professionals

As the accumulation of experiencing and daring to participate are significant aspects influencing the healthcare professionals' learning processes, it can be recommended to implement music-based approaches into the professional studies of nurses and caregivers. Familiarising students with person-centred musical approaches during their studies, in a form of onsite observation in the MiMiC or Music and Dementia practices and related course work, may be effective for supporting the students' openness to participate in music projects in their future workplaces.

Furthermore, in line with the forestudy on Music for Life (see section 2.1.1), there is a need for additional learning opportunities and staff training for caregivers who participate in the Music and Dementia practice in the Netherlands. The reason for this is that the caregivers appear to be willing and motivated to continue using music at work, yet, they must be sufficiently supported in order to do so[141]. Also, the findings of this research suggest that there is a need for increased support for the caregivers' participation in the circle prior to the beginning of a Music and Dementia project, as well as during it.

In addition, based on the outcomes of the group discussions, there could be merit in implementing collective reflection among groups of nurses or caregivers as an integrated part of the music practices. The possibilities of enhancing the groups' negotiated meaning-making (see Lave & Wenger, 1991) of the musical experiences can, hence, be further explored.

6.5.2.2. Practical considerations and implications for musicians

The findings of this research suggest that the music practitioners of both Music and Dementia and MiMiC may seem predominantly focused on facilitating patients and residents' musical engagement in the music sessions. Since it appears that there is a need for a stronger emphasis on the healthcare professionals' participation and experiential processes in future music projects, communication about their involvement and inclusion in the music-making could be improved between music practitioners and healthcare

141 Currently, intensive staff training opportunities are arranged in the Netherlands for caregivers, volunteers and family caregivers by the organisation Embrace Nederland. The focus of the training is to help the participants to carry out music-making after the end of a Music and Dementia project (see Embrace Nederland, n.d.).

professionals.

This research argues that the healthcare professionals in both practices did not fully seem to recognise that the music practices were intended to support their own learning and well-being at work. Furthermore, as previously discovered, some of the narrative accounts on the Music and Dementia practice reveal that the caregivers were not always sufficiently prepared for their participation in the music projects. Thus, there is an urgent need for both musicians and project managers to improve the caregivers' participation preparation before the beginning of future projects. Moreover, it appears that the MiMiC musicians need to further develop their approaches of dealing with the nurses' professional distance and helping to increase the nurses' agency in the music sessions.

There is a need for the musicians in both practices to support the healthcare professionals' participation and sense of inclusion through developing stronger strategies for encouraging their engagement in the musical processes. The musicians' interpersonal values, e.g. hospitality (Higgins, 2008, 2012; Lines, 2018), are crucial for creating inclusion and acknowledgement of the healthcare professionals in the music sessions. Thus, the need for specialised training into participatory person-centred music-making in healthcare for musicians in higher music education is clear. Furthermore, particularly in the MiMiC practice, the musicians need to be well-prepared with a wide range of musical approaches (see also Smilde et al., 2019) to be able to connect with the healthcare professionals, especially in the delicate early stages of 'familiarisation' at the beginning of a music project, where doubt and hesitation may be present (see Dewey, 1916/2009 in section 3.1.4).

It can, furthermore, be recommended to run a preliminary introduction session exclusively for the caregivers taking part in a Music and Dementia practice before a future project begins. A preparatory session may help the caregivers to be familiarised with the music practice thoroughly. In particular, it is relevant to support the caregivers' understanding of what to expect in regard to the processes of music-making and collaboration with the musicians, as well as to provide access to try some of the musical approaches out in practice.

This research proposes that musicians can become important collaborators for and artistic allies of healthcare professionals by supporting and acting out the person-centred values of care. In the MiMiC practice, this aspect was emphasised in observed moments when the musicians facilitated person-centred engagement in the patients' rooms while the nurses were unable to be present due to time pressure.

6.6. Evaluation of the research

In the constructivist grounded theory canon, this research has aimed to give presence to the participants' voices within the conceptualised analysis (see Charmaz, 2006; Mills et al., 2006). Upon the pragmatist philosophy, the research understands the meaning of experiential knowledge in relativist-subjectivist terms: it can have a different meaning for different individuals in the time and culture where they live. Therefore, the research does not claim absolute truth, although it assumes that the research participants have told and shown their truths. Instead, in line with Charmaz (2006) and Bisschop Boele (2013), this research has aimed to offer a *plausible explanation* of the empirically grounded findings in

the participants' social contexts.

When evaluating the rigour of the research design retrospectively, it can be concluded that the triangulation of participant observation, episodic interviews and group discussions have led to plausible interpretations and conclusions of the data. The research has interpreted primarily healthcare professionals' situational, episodically organised knowledge and meaning of participatory music practices. The findings are, therefore, densely situated in the immediate episodic framework of the music sessions. They should, hence, only be viewed in relation to the situational contexts of the study and not be generalised outside said contexts.

The research design of the study has intentionally excluded observations of the social situations in the care units outside the music session time. Furthermore, this research is not an organisational study, nor a study into healthcare policy. As a sociocultural research project, the study can contribute to improving aspects of care culture, quality of care and healthcare professionals' well-being in the workplace, as well as musicians' professional practice. Lastly, although the participants of this research were overwhelmingly female-dominated, gender has not been weaved in as a thread of the study, as it did not emerge as a category from the coding process.

6.7. Future research

It can be speculated that continuing future research with added observations outside the time of the music sessions might be beneficial for finding out what happens in the care units when the musicians are not there, and also, what kind of observable social change can take place between the sessions and once the musicians leave. Even further, investigating how the social changes catalysed by music-making in the workplace might support healthcare professionals' personal resources in their private settings could perhaps be relevant for gaining a deeper holistic understanding of the impact of the music practices.

Also, when both of the two music practices, MiMiC and Music and Dementia, will have become established as long-running practices, it will be interesting to conduct a future study to find out what their long-term legacies are for the healthcare professionals' learning and well-being.

Given the genderedness of the nursing and caregiving professions, conducting future research into the aspects of live music, gender and social change in healthcare may be considered as relevant to finding out how the participatory music sessions can support or possibly empower the female workforce, in particular.

Finally, carrying out mixed-methods research connecting qualitative findings on nurses' and caregivers' musical experiences with quantitative evidence on their occupational well-being can be considered as a valuable step for future research.

6.8. Last reflective remarks

I started this research as a foreigner to the context of healthcare, although I was equipped with experience of participatory music-making with elderly people with dementia. Nevertheless, my experience did not prepare me for the chaotic and unpredictable realities of the healthcare professionals' working life. As I began observing and interviewing the healthcare professionals individually and collectively, I was humbled by their willingness to take part in my research, even when they sometimes would be paged by a patient in the middle of an interview. They would always return to finish the interview. During the research process, although I aimed to remain as neutral as possible, I was often moved by the healthcare professionals' earnestness to provide the best care possible to their patients and residents. I furthermore found it remarkable how quickly the healthcare professionals accepted the musicians' contributions to the care delivery, even if many of them felt initial scepticism toward the value of live music in their workplace.

I recognise that the healthcare professionals have shown tremendous trust by allowing the musicians the access to their patients and residents, but also by sharing deeply personal experiences of the music sessions with me for the benefits of this research. Therefore, I have aimed to treat these accounts with the highest integrity and respect in this dissertation. For example, my intention is not to suggest that participatory music practices make healthcare professionals more compassionate towards their patients and residents, but rather, that the music practices create opportunities and resources for a compassionate display of care by evoking positive emotional resonance and contact.

Finally, it was helpful for me to visualise the two main lines of experiential developments of the learning and social changes as 'opening and enclosing', something inspired by Vincent van Gogh's series of 'Sunflowers' (1888-1899). First, the opening of the sunflowers served as an analytical metaphor for seeing other people open up socially and emotionally through the music-making and letting oneself open in return. Second, the sunflowers' facing the sun together served as an analytical metaphor for the social 'enclosing': getting closer to each other on a shared 'frequency' of interconnectedness and emotional resonance. Nurse Josephine's (see section 5.2.4.4) reflection demonstrates these two metaphoric ideas:

> "*It brought me happiness. I loved it that it became a piece of us two [the patient and me] together. And that [the musicians] brought me closer to that patient.*"

Reflecting on the observations and narrative accounts that I have collected and analysed, I realise that the metaphor of 'opening and enclosing', envisioned with the help of van Gogh's sunflowers, accentuates the essence of the findings: creating circumstances for *flourishing* within kairotic moments of shared musical experiencing and legacies that are rooted in experiential *growth*.

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8. APPENDICES

Appendix 1. A. Informational letter to research participants – MiMiC

Short description of the PhD research

Legacy: Participatory Music Practices with Elderly People as a Resource for Healthcare the Well-being of Healthcare Professionals is the PhD research of Krista de Wit (University of Music and Performing Arts Vienna). The research focuses on what interactive participatory music practices and musical communication can mean for the nurses and their communication with their patients. The research looks into two different contexts of elderly care: the surgical departments of the UMCG, where most of the patients are 60 years of age or older, and nursing home care for elderly people with dementia.

The aim of the research is to find out what the nurses' participation in the music sessions can mean for their learning and well-being, and what kind of small social changes can follow on the wards. The research is carried out by observing, interviewing individual nurses and holding group discussions with groups of colleagues of the ward. The questions are interested in how *you* have experienced the music sessions and what their impact was for yourself.

My research at the UMCG

My research data collection takes place right after the music sessions at the UMCG during the period of October 2016 – May 2017. I aim to interview four nurses on each ward who have been at work during the music project. Also, I would like to have a group discussion with all the nurses that can be present. The language of the interviews and group discussions is Dutch.

The group discussions take place on the last day of the project in the coffee breakroom and the interviews will be planned for the week after the project. You are very welcome to contribute to the discussion. The group discussions and the interviews take maximally 60 minutes and they will take place during work hours. Your participation is highly appreciated and important for my research. Hanneke van der Wal-Huisman will be in contact with you to plan the interviews with your head nurse at the beginning of the month when the project takes place at the ward.

Privacy and consent

The participation in the interviews and group discussions is absolutely voluntary. All information will be handled confidentially. All narrative accounts will be fully anonymised, so no names will be published. The interviews and group discussions will be audio recorded so that they can be transcribed. The audio recordings will be stored safely on my private OneDrive-database of the Hanze University of Applied Sciences Groningen. After the completion of the research, they will be destroyed.

I would kindly like to ask for your consent to audio record the interviews and group discussions, and to quote your accounts in my dissertation anonymously. I am happy to provide more information about my research. You can contact me via email or phone.

With kind regards,

Krista de Wit (MMus, MMusEd)
Teacher-researcher at the Prince Claus Conservatoire

Appendix 1. B. Informational letter to research participants – Music and Dementia

Dear caregiver,

My name is Krista de Wit. I am working towards a PhD degree at the Institute of Music Education of the University of Music and Performing Arts Vienna. My research, *Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals* focuses on what interactive participatory music practices and musical communication can mean for nursing home caregivers and their communication with the residents. The research looks into two different contexts of elderly care: the surgical departments of the UMCG, where most of the patients are 60 years of age or older, and nursing home care for elderly people with dementia.

I have been in contact with your manager [first name, last name] and discussed the possibility to interview caregivers who are going to participate in the upcoming Music and Dementia project at your workplace. So, in the framework of my research, I would very gladly like to interview *you* as a caregiver taking part in the music project. Additionally, I would like to ask you to join one group discussion at the end of the music project together with your colleagues.

The themes of the interviews and the group discussion are focused on what you have experienced in the music sessions and what kind of meaning those experiences can have for your work, the care and your well-being. Everything that is important for you to tell is important for the interviews, and my aim is to facilitate your personal reflections. The interviews and group discussions will last a maximum of 60 minutes and they can be held at a time that is the most suitable for you.

My plan is to interview two caregivers twice during the project (once in the middle and once at the end of it) and hold one group discussion at the end of the project. The language of the interviews and group discussions is Dutch.

Participation in the interviews and group discussions is absolutely voluntary. All information will be handled confidentially. All narrative accounts will be fully anonymised, so no names will be published. The interviews and group discussions will be audio recorded so that they can be transcribed. The audio recordings will be stored safely on my private OneDrive-database of the Hanze University of Applied Sciences Groningen. After the completion of the research, they will be destroyed.

I would kindly like to ask for your consent to audio record the interviews and group discussions, and to quote your accounts in my dissertation anonymously.

Would you like to take part in my research? Please let me know about your availabilities for the interviews for the coming weeks. Many thanks in advance for your response. I am happy to provide more information about my research. You can contact me by email or phone.

With kind regards,

Krista de Wit (MMus, MMusEd)
Teacher-researcher at the Prince Claus Conservatoire

Appendix 2. Informed consent form

Informed consent form (ICF)

I give permission to Krista de Wit, a doctoral student at the University of Music and Performing Arts Vienna and a member of the Lifelong Learning in Music research group of Hanze University of Applied Sciences, to use the qualitative interview and observation data I have been involved in as empirical data for her doctoral dissertation *Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals*. The PhD research investigates the meaning of creative participatory music practices for the learning and well-being of healthcare professionals working in elderly care homes and in hospital wards. The research takes place during the period of January 2016-July 2020 in the Netherlands.

I am participating in this research interview entirely voluntarily. I approve the analysis and publication of the transcription of this interview for Krista's PhD research, provided that the contents are handled with full anonymity and confidentiality.

Place and time (day/month/year) _____

Signature and print name _____

_____

I confirm that the interview respondent was given an opportunity to ask questions about the research study. All the questions asked by the respondent have been answered truthfully and to the best of my ability. I confirm that the respondent has given consent to use this interview as research data freely and voluntarily.

Place and time (day/month/year) _____

Signature and print name _____

Krista de Wit (née Pyykönen), MMus, MMusEd

Appendix 3. A. Episodic interviewing plan: themes and topics of interest

Phase 1) Introduction

I am a musician, music researcher and pedagogue. So, I come from a very different work culture than you. For my PhD research, I would like to know what you encounter in your daily life and what challenges it brings to you. And then, what the music project that has been carried out here last week can mean for you personally, for your learning, your work with patients / residents and for your well-being in the workplace.

We are here to talk about your personal experiences within the music sessions, in which you have participated with the patients / residents, musicians and your colleagues. This is an open-ended narrative interview, so I am not going to interrupt your story. Everything that is important for you to tell is important for the interview. I would like to ask you to describe your experience in your own words.

Phase 2) Biographical questions about the interviewee's relationship with the research topic:

1) Could you tell me about yourself and about your daily working life?

2) What significance does music have for you? Personally, and at work?

3) Can you describe the daily communication between you, your colleagues and your patients/residents?

Phase 3) Episodic questions about meaningful moments in the music project:

4) Can you describe to me what you have seen, heard or experienced during the music project?

5) Were there moments that were important to you? Which ones? Can you describe them for me?

6) What made these moments stand out for you?

Phase 4) Episodic questions about participation - deepening of the narrative:

7) In what ways did you participate in the sessions?

8) In what ways was the music made for you, and what significance did it have for you?

9) What feelings did the musical participation evoke?

10) How would you describe the communication between the musicians and the other

participants during the music sessions?

Phase 5) Meaning and learning - expanding the scope of the narrative:

11) What new insights or knowledge did you gain from the music sessions?
- Have you experienced changes or seen new sides of your patients/residents or in yourself?

12) What can the new insights and knowledge give to your work?

13) What can the music sessions give to the care and to your relationship with the patients/residents?

14) What can the music sessions provide for your work environment?

15) What do you find important about the music for your workplace and your well-being at work?

16) What can the music mean for you and your colleagues?

17) What did the music mean to the ward and the patients/residents after and between the music sessions?

18) What more have you learned through participating and observing in the music sessions?

Phase 6) Evaluation and small talk

- additional questions
- thanks for the participation and information about the completion of the research

Appendix 3. B. Group discussion plan: themes and topics of interest

Phase 1) Introduction:

I am a musician, music researcher and pedagogue. So, I come from a very different work culture than you. For my PhD research, I would like to know what you encounter in your daily life and what challenges it brings to you. And then, what the music project that has been carried out here last week can mean for you personally, for your learning, your work with patients / residents and for your well-being in the workplace.

We are here to talk about your personal experiences within the music sessions, in which you have participated with the patients / residents, musicians and your colleagues. This is an open-ended narrative interview, so I am not going to interrupt your story. Everything that is important for you to tell is important for the interview. I would like to ask you to describe your experience in your own words.

Phase 2) Generative narrative opening: varying provocative stories for initiating the conversation

Phase 3) Central discussion topics (in line with interviews questions, see appendix 3A)

- questions about the meaning of music for the work and care
- questions about job resources
- questions about meaningful moments in music sessions
- questions about contact with patients / residents, musicians and colleagues in the department and in the music sessions
- questions about participation in the music sessions
- questions about emotional experiences through the music
- questions about aspects of personal well-being in the workplace and in the music sessions
- questions about teamwork and collaborative learning in the workplace
- questions about the meaning of learning through the music sessions
- questions about new insights and knowledge for working life and care delivery

Phase 4) Evaluation and small talk

- additional questions
- thanks for the participation and information about the completion of the research

9. SUMMARIES

9.1. Summary

'*Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals*' is a qualitative research project into the learning and well-being of hospital nurses and nursing home caregivers working with vulnerable elderly people and participating in live music practices *Meaningful Music in Healthcare (MiMiC)* and *Music and Dementia*. The research questions were:

1) *What kind of knowing is transferred from interactive music sessions into daily healthcare practices in elderly care and hospital settings?*

2) *What resources and social changes can music sessions generate for the nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?*

The research investigated healthcare professionals' experiences of live music in their workplace. After a forestudy, two empirical studies were carried out in the Netherlands. First, on *Meaningful Music in Health Care (MiMiC)* on three surgical wards of the University Medical Center Groningen. Second, on *Music and Dementia* in three nursing homes. The data collection (2016-2019) employed an ethnographic approach (Atkinson & Hammersley, 2007) and data triangulation of participant observation (Kawulich, 2005), episodic interviews (Flick, 1997) and group discussions (Bohnsack, 2004). The constructivist grounded theory approach to data analysis proceeded from sensitising concepts to *initial* and *focused* coding (Charmaz, 2006), ultimately reconstructed into a *thick description* (after Geertz, 1973) merging empirical data, theory and the researcher's interpretations (Alvesson & Sköldberg, 2018).

The emerging core categories, *Participation*, *Experience* and *Learning benefits*, were conceptualised within an epistemological framework of philosophical pragmatism. Dewey's (1938/2015) notions of '*experiencing*' theorised experiential learning and the '*pragmatic value*' of musical experiences. Mead's (1934/2015) '*social self*' conceptualised relational aspects of learning. Lave & Wenger's (1991) '*situational learning*' and '*communities of practice*' theorised participation in the music sessions. Goffman's (1959/1990) '*performance of self*' conceptualised social interaction therein. Two theories of well-being, PERMA (Seligman, 2011) and Job Demands-Resources (JD-R) (Bakker & Demerouti, 2014), as well as notions of Positive Psychology and compassion studies (Ricard, 2013), conceptualised occupational flourishing and emotionality. Other concepts were '*person-centred care*' (Kitwood, 1997), music as a '*reflexive change agent*' (DeNora, 2000), '*participatory music*' (Turino, 2008; Higgins, 2012), '*person-centred music*' (Smilde et al., 2014, 2019), '*mindful presence*' (Langer, 1989; Van Heijst, 2005) and '*Kairos*' (Sipiora 2002).

The findings suggest that, through an emerging community of practice, healthcare professionals could collaborate with musicians to connect with patients or residents. The collaboration enabled the use of shared musical experiences as a resource for compassion-

ate care. Still, allowing oneself to participate musically and showing emotional vulnerability were challenging. The accumulation of 'experiencing' and collegial encouragement supported healthcare professionals' participation *beyond* their *professional performance*.

Person-centred music-making resonated with the values of person-centred care. It enabled healthcare professionals to take time and become engaged with patients or residents in musical situations. Healthcare professionals described gaining new understandings of the patients or residents and each other, which could be seen promoting a cultural shift from task-centredness towards relationship-focused person-centred care.

Musicians' communication provided new professional insights into teamwork. Also, observing patients and residents' responses to the music evoked sympathetic joy (Jormsri et al., 2005) in healthcare professionals. Looking through the eyes of 'the other' was central for nurses and caregivers' meaning-making of the value of music-making and awareness of its impact on patients, residents and themselves. The perceived benefits of the music practices for healthcare professionals' job resources and satisfaction seemed connected to changes in care relationships, work atmosphere, sense of mindfulness and recognition.

The conclusions of the research suggest that participatory music practices might be considered as supportive of delivering person-centred care. The findings could be applied in training programmes and professional development of musicians, nurses and caregivers.

9.2. Zusammenfassung

'*Legacy: Participatory Music Practices with Elderly People as a Resource for the Well-being of Healthcare Professionals*' ist ein qualitatives Forschungsprojekt über Erfahrungslernen und Wohlbefinden von Angehörigen der Gesundheitsberufe, die mit älteren Krankenhauspatienten und Pflegeheimbewohnern mit Demenz arbeiten. Die Forschung konzentriert sich auf die Lernentwicklung von Krankenschwestern und Betreuern in partizipativen Musikpraktiken wie *Meaningful Music in Healthcare (MiMiC)*[142] *und Music and Dementia*[143]. *Die Forschungsfragen sind:*

1) *Welche Art von Wissen wird von interaktiven Musiksitzungen in die täglichen Gesundheitspraktiken der Alten- und Krankenpflege übertragen?*

2) *Welche Ressourcen und soziale Veränderungen können Musiksitzungen für die täglichen Abläufe der Krankenschwestern und Pflegekräfte generieren und welche Auswirkungen können sie auf die Kultur ihres Arbeitsumfelds haben?*

Die Studie untersucht die individuellen und kollektiven Erfahrungen der Forschungsteilnehmer und die Sinnfindung von Musikprojekten an ihrem Arbeitsplatz. Nach einer Vorstudie wurden zwei empirische Studien in den Niederlanden durchgeführt. Die erste konzentrierte sich auf Live-Musikpraxis in drei chirurgischen Stationen des Universitätsklinikums Groningen (UMCG), die zweite Studie fokussierte die Musikpraxis in drei Pflegeheimen für ältere Menschen mit Demenz. Die Forschungsdaten wurden durch einen ethnographisch fundierten Forschungsansatz (Atkinson & Hammersley, 2007) generiert. Methoden der Datenerfassung waren teilnehmende Beobachtung (Kawulich, 2005), episodische Interviews (Flick, 1997) und Gruppendiskussionen (Bohnsack, 2004). Die Daten wurden zwischen 2016 und 2019 gewonnen und durch Datentriangulation (Olsen, 2004) validiert. Die qualitative Datenanalyse verwendete einen konstruktivistisch fundierten Grounded-Theory-Ansatz (Charmaz, 2006). Die Analyse wurde als „dichte Beschreibung" (Geertz, 1973) konzipiert, in der die empirischen Daten, der theoretische Wissensbestand und die Interpretationen der Forscher synchronisiert wurden (Alvesson & Sköldberg, 2018).

Die Kernkategorien, die sich aus dem analytischen Kodierungsverfahren ergaben, waren: „Partizipation", „Erfahrung" und „Lernfortschritt". Diese Kategorien basieren theoretisch auf Konzepten des amerikanischen Pragmatismus, namentlich auf Deweys (1938) Idee des „Erlebens", um den Wert der musikalischen Erfahrungen zu konzeptualisieren. Meads (1934) Vorstellung vom „sozialen Selbst" war die Grundlage für die relationalen Aspekte der Lernprozesse. Die Konzepte von Lave & Wenger (1991) zum „situativen Lernen" und der „Community of Practice" machten das Lernen der Forschungsteilnehmer in den Musiksitzungen an ihrem Arbeitsplatz verständlicher. Goffmans (1959) Vorstellung von einer „Performance of Self" half, das *Impression Management* der Pflegenden und Betreuer in den Musiksessions zu verstehen. Darüber hinaus stützte sich die Forschung auf Modelle des Wohlbefindens (PERMA Modell nach Seligman, 2011, und Job Demands-Resources-Modell nach Bakker & Demerouti, 2014). Zusätzliche Anregungen kamen aus dem Bereich

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143 *Musik und Demenz*

der Positiven Psychologie (Compton & Hoffman, 2013), der Empathieforschung (Gilbert & Choden, 2013; Ricard, 2013), der „personenzentrierte Pflege“ (Kitwood, 1997), der Musik als „reflexiver Anregerin“ (DeNora, 2000), der „personenzentrierte Musik“ (Smilde et al., 2014, 2019) sowie dem Konzept des „Kairos“ (Sipiora 2002).

Die Ergebnisse der Forschung legen nahe, dass die „kairotischen“ Qualitäten des personenzentrierten Musikmachens es den Pflegenden und Betreuern ermöglichten, sich Zeit zu nehmen, präsent zu sein und sich in musikalischen Situationen sozial mit den Patienten zu beschäftigen. Die Beobachtung der Reaktionen der Patienten rief bei den Angehörigen der Gesundheitsberufe eine emotionale Resonanz und eine tiefe Sympathie für das wahrgenommene „Aufblühen“ der Klienten hervor. Die erlebten Vorteile der Musikpraxis schienen mit Veränderungen in der Pflegebeziehung, der Arbeitsatmosphäre sowie dem Gefühl der Achtsamkeit und der persönlichen Anerkennung verbunden zu sein, die ihr berufliches Wohlbefinden erhöhten.

Die Schlussfolgerungen der Forschung legen nahe, dass partizipative Musikpraktiken als Unterstützung einer personenzentrierten Betreuung angesehen werden können und somit in Ausbildungsprogrammen und in der beruflichen Praxisentwicklung von Musikern, Krankenschwestern und Betreuern institutionalisiert werden könnten.

10. ACKNOWLEDGEMENTS

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Funding for this research was obtained from Hanze University of Applied Sciences Groningen, Research Group Lifelong Learning in Music and Prince Claus Conservatoire. I am grateful to have received their support for my research. Being admitted to carrying out this research in the Young PhD researcher programme (Jonge Promovendi) has been an honour. I am thankful to the University of Music and Performing Arts Vienna (MDW) for admitting me into the Institute of Music Education. Thanks also to my peer-musicians of Foundation MiMiC Muziek for their collegiality, friendship and musical collaboration. When it comes to the other musical means of support, I thank Max Richter and Philip Glass for tuning me into the writing mode time and time again.

Finally, I would like to thank my dear friends and my family: my mother Mari and my brother Ilari for their encouragement and advice, especially during my previous academic studies leading up to this dissertation, as well as my extended de Wit family for their optimistic outlook on my research process. Ultimately, I want to give my most heartfelt thanks to my husband, Peter, for his endless support and compassion as my companion every step of the way.

11. CURRICULUM VITAE

Krista de Wit (née Pyykönen) was born in Helsinki, Finland on December 27th, 1986. She is a teacher-researcher in higher music education, community musician, violin pedagogue and a left-handed violinist. She works in the research group Lifelong Learning in Music of the Hanze University of Applied Sciences Groningen and teaches master students at the Prince Claus Conservatoire in Groningen. In 2006, Krista began her studies in the degree programme Bachelor of Classical Music Education at Metropolia Helsinki University of Applied Sciences. She carried out her bachelor research, "The Devil Plays Left-Handed – Are Lefty Violinists Diabolic?" on the experiences of left-handed violinists, which was graded 5/5 and led to her first invited research presentation at the Finnish String Teachers' Association in 2011.

Krista continued her studies in the international degree programme NAIP – European Master of Music at the Royal College of Music in Stockholm in 2011, where she carried out a practice-based research project "Many Memories, Many Stories" into participatory music-making with Finnish-speaking elderly people with dementia living in Stockholm. Her research was awarded the Kerstin Eliasson-prize of Excellence in Master Research in December 2013. Krista presented her research findings at a Gerontology Conference at the University of Helsinki in 2013 and the Music and Dementia symposium in Amsterdam in 2014. While working as a teacher at the Royal College of Music in Stockholm (2013-2015), Krista continued her studies in the degree programme Master of Music Education. She finished her studies at the Royal College of Music in Stockholm in 2015 with a master's thesis, "A Handful of Considerations – Perspectives on Left-Handedness in Violin Playing and Violin Pedagogy" examining the conventions of violin pedagogy for teaching left-handed pupils. She presented her findings at the ESTA Sweden conference in Malmö in 2015. Krista has continuously worked in the international NAIP network since 2013.

In late 2015, Krista enrolled as a PhD-candidate at the Institute of Music Education at the University of Music and Performing Arts Vienna (MDW), while employed at the Prince Claus Conservatoire, where she teaches music pedagogy, a *Music and Healthcare* module which prepares students to work in the *MiMiC* and *Music and Dementia* practices, and coaches master students to carry out practice-based research. Krista entered the "Young PhD researcher" programme of Hanze University in January 2016. During her PhD study, Krista was involved in the development of the *MiMiC* practice (2015-2017) and the follow-up research project *ProMiMiC* (2019-2023) into the professionalisation of MiMiC musicians and nurses. Krista has presented in various international conferences (e.g., The Reflective Conservatoire Conference in London in 2018, The AEC-Congress and General Assembly in Graz in 2018, and the SIMM-posium 2 conference in London in 2017).